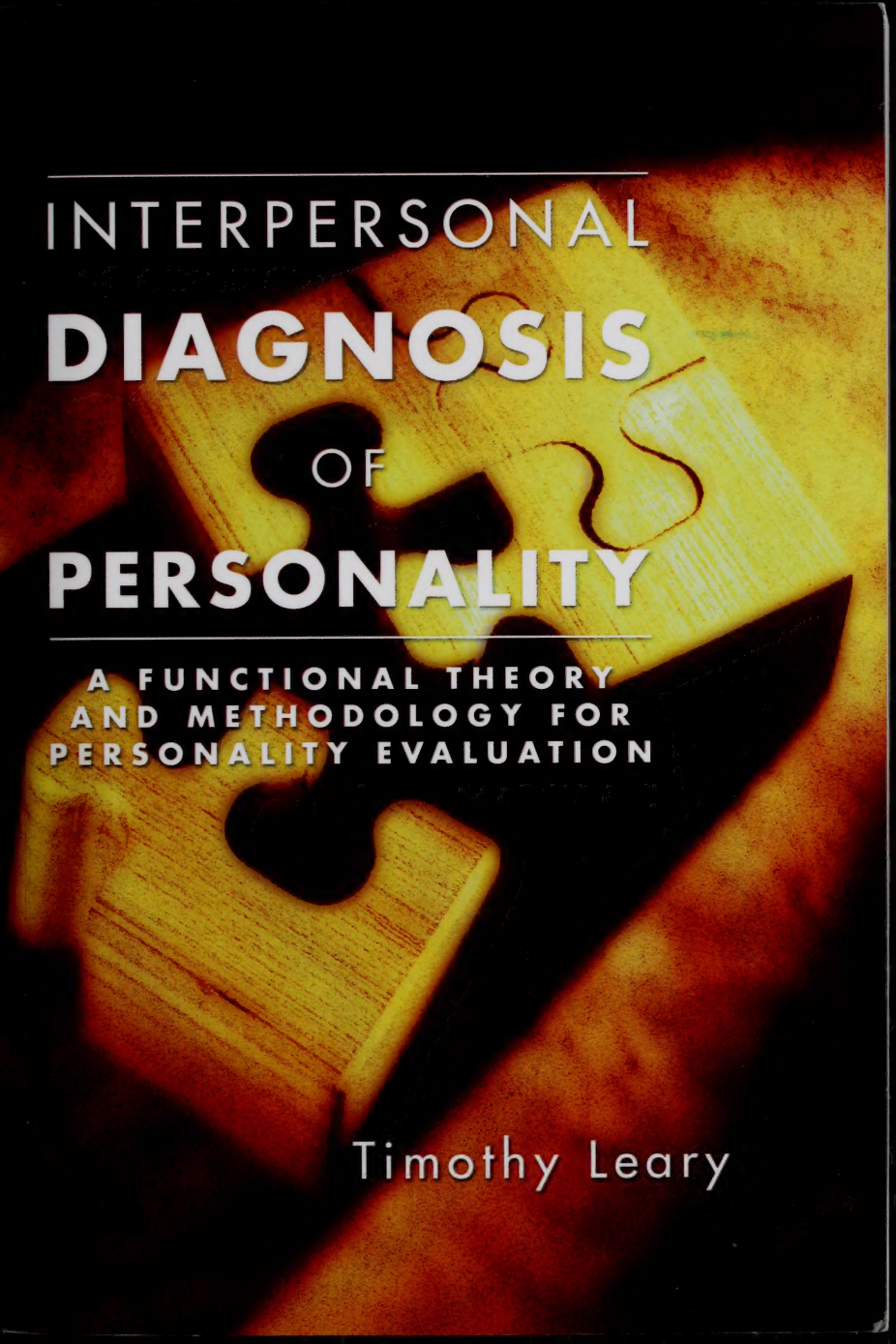

INTERPERSONAL
DIAGNOSIS
OF
PERSONALITY
A FUNCTIONAL THEORY
AND METHODOLOGY FOR
PERSONALITY EVALUATION
Timothy Leary

Interpersonal Diagnosis of Personality

A Functional Theory and Methodology for Personality Evaluation

TIMOTHY LEARY
DIRECTOR OF PSYCHOLOGY RESEARCH
KAISER FOUNDATION HOSPITAL
OAKLAND, CALIFORNIA

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To

Marianne Leary

Preface

This book is concerned with interpersonal behavior, primarily as expressed and observed in the psychotherapeutic setting. Its value lies in its emphasis on the complexity and variety of human nature and on the objectivity and clarity of the empirical procedures it sets forth for multilevel diagnosis. The research on which it reports was made possible by grants from the United States Public Health Service and the Kaiser Foundation.

The interpersonal factors of personality are those conscious or unconscious processes which people use to deal with others and to assess others and themselves in relation to others. The aim of the interpersonal machinery of personality is to ward off anxiety and preserve self-esteem. One of the major results of these operations is to create the social environment in which each person lives.

Everyone tends to make his own interpersonal world. Neurosis or maladjustment involves the limiting of one's interpersonal apparatus and the compulsive use of certain inflexible, inappropriate interpersonal operations which bring about results that are painful, unsatisfactory, or different from one's conscious goals. Adjustment is characterized by an understanding of one's personality structure, by the development of mechanisms flexible enough to deal with a variety of environmental pressures, and by the management of one's behavioral equipment in such a way as to avoid situations where the mechanisms will be ineffective or damaged.

Any statement about human nature, however, is restricted in meaning unless the level of behavior to which it refers is made clear. The first step must be a definition of levels and an ordering of data in terms of levels. The aim of the research work described in this book has been to develop a multilevel model of personality and to present a series of complex techniques for measuring interpersonal expressions at these different levels of personality. A conceptual and empirical method for converting observations of interpersonal behavior is set forth. The reader will encounter new theories about the effect of interpersonal behavior, the meaning of fantasy expressions, the social language of symptoms, and the nature and functional meaning of conflict. These theories and systematic procedures constitute the Inter-

personal System of Personality, developed by the Kaiser Foundation Psychology Research Project.

The approach employed might be called a *dynamic behaviorism.* There are two dynamic attributes. The first refers to the impact one person has or makes in interaction with others; the second refers to the interaction of psychological pressures among the different levels of personality. The behavioristic attributes of the system derive from the procedure of viewing every response of the subject (overt, verbal, symbolic) as a unit of behavior which is classified by objective methods and automatically sorted into the appropriate level of personality. The patterns and clusters of thousands of these responses, sorted into different levels, are then converted by mathematical techniques into indices and into a multilevel diagnostic code summary. These are then related to clinical events or prognoses. In the development of the interpersonal system more than 5,000 cases (psychiatric, medical, and normal controls) have been studied and diagnosed.

In addition to describing and validating the process of interpersonal diagnosis in the psychiatric clinic, this volume demonstrates how these theories and methods may be applied in four other practical settings—in the psychiatric hospital, in psychosomatic medicine, in industrial management, and in group therapy.

This book should be interpreted in the light of its environmental and professional contexts. It is the product of clinical psychologists working in a psychiatric setting, and practical answers have been required of the interpersonal system at each stage of its development. This gives the book its functional cast. As to its implications for the profession of psychology, in my own mind at least, a new concept of the "clinical psychologist-as-diagnostician" has emerged. In the Introduction, I have detailed the genesis of the research which has resulted in the book, and have set forth the contributions of the many people who have helped to bring it to fruition.

TIMOTHY LEARY

Berkeley, California
October, 1956

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Introduction

In the past, the complexity of personality data, particularly as it is observed in the clinical setting, has led to a relative neglect of empirical studies and to an emphasis on anecdotal, speculative accounts. Where objective investigations have been undertaken, they have tended to be analyses which employed a single testing instrument. This is a result of the sociological development of the testing psychologist's role.

The original and basic aim of the Kaiser Foundation Psychology Research was (and still is) the study of "process in psychotherapy." The first steps in this direction involved the construction of a systematic way of viewing personality structure before therapy. This model system is necessary to predict what will happen in therapy and to measure change in structure during and after therapy. This book presents such a system and some of its diagnostic and prognostic features.

The United States Public Health Service supported the research project by a series of six annual grants, from 1950 to 1954, under the directorship of Hubert S. Coffey and Dr. Saxton T. Pope, Jr., and from 1954 to 1956 under the direction of Timothy Leary. In addition to serving as the first director, Hubert Coffey has been chief advisor since the first days of the project. Dr. Pope provided research facilities and clinical wisdom, and was of signal help in developing the concept of variability indices, discussed in Chapter 13.

The Kaiser Foundation contributed substantially to the research during the years 1950–1954, and from November 1954 assumed major support of the core project. Dr. Harvey Powelson became the director of the research project in 1951. He has given clinical advice, theoretical counsel, and administrative support throughout the duration of the research.

In its development, the interpersonal system of personality has been influenced by many collaborating psychologists and psychiatrists. It is impossible, in a cooperative, creative enterprise of this scope to accord specific credit for all contributions, and the following acknowledgments indicate only the major indebtedness. Those whose names are listed below should not, however, be held accountable for any

weaknesses in the theoretical design. Full responsibility for the present version of the system is assumed by the author.

The basic notion of the interpersonal classification system (the circle) was developed in 1948–1949 by Hubert Coffey, Mervin Freedman, Timothy Leary, and Abel Ossorio. The same group was responsible for the original tripartite definition of levels. The psychotherapy groups which provided the original data for classification of interpersonal reflexes were organized with the help and sponsorship of J. Raymond Cope, of the Unitarian Church of Berkeley.

Dr. Mary Sarvis, Kaiser Foundation Psychiatric Clinic, lent her diagnostic and therapeutic knowledge to the research group with unsparing generosity.

Mervin Freedman was a major participant in every stage of theoretical and methodological development from 1948 to 1953. His thoughtful, analytic approach provided balance and good sense.

Rolfe LaForge is responsible for the successful aspects of the statistical and methodological work. From 1950 to 1954, he directed the testing program, the IBM research, the check-list studies, and served as statistical consultant.

Martin Levine, Blanche Sweet, Herbert Naboisek, and Ellen Philipsborn Tessman made theoretical contributions and aided in the processing of data.

Jean Walker McFarlane was an original sponsor and advisor of the research project and contributed continuous editorial and practical assistance.

Arthur Kobler of the Pinel Foundation Hospital, Seattle, has employed the diagnostic system in his studies of psychotic patients. The combination of his empirical help and theoretical counsel has strengthened this book in several areas.

Bernard Apfelbaum collaborated in the early stages of the oscillation-variability theory. He also provided ratings of interpersonal behavior, as did Wanda Bronson, Albert Shapiro, and Marvin Spanner.

Frank Barron has served since 1950 as official and unofficial consultant to the research project. He helped design the original test battery and provided valuable editorial and methodological assistance.

Psychotherapy groups studied by the research project were in charge of Dr. Jean Neighbor, Mary Darby Rauch, Shirley Hecht, Mervin Freedman, Stephen Rauch, Abel Ossorio, Dr. Harvey Powelson, Robert Suczek, Hubert Coffey, Patrick Sullivan, and Richard V. Wolton. Richard Wolton also lent his assistance in the collection of data and in manuscript preparation.

A most important aspect of the interpersonal system is that the test administration, scoring, and rating of tests—as well as the determination of the multilevel diagnoses and the indices of conflict—are accomplished by highly trained technicians who are not professional psychologists. The technical staff responsible for the multilevel diagnoses of the 5,000 cases on which this book is based, includes Anne Apfelbaum, Elizabeth Asher, Mary della-Cioppa, Roberta Held, Charlotte Kaufmann, Joan Harvey LaForge, Helen Lane, and Barbara Lennon Nicholls. Gloria Best Martin was Research Administrator for the years 1950–1952.

The countless administrative decisions necessary to maintain the day-to-day operations of the research project have been handled with competence by Miss Helen Lane. She has had final executive responsibility for data collection, office management, and manuscript preparation.

I

Some Basic Assumptions About Personality Theory

1

Interpersonal Dimension of Personality

The twentieth century may well find historical status as the epoch in which man began to study himself as a scientific phenomenon. This development, inaugurated mainly by Sigmund Freud around the year 1900, has brought about an impressive growth in the so-called humanist disciplines—psychiatry, psychology, anthropology, sociology. The hour is yet too early to begin writing the chronicles of our time, but certain trends, now clearly evident, allow tentative predictions.

The study of human nature appears, at this mid-century point, to be shifting from an emphasis on the individual to an emphasis on the individual-in-relation-to-others. During the last fifty years the subject matter of psychiatry, for example, has moved away from case history and symptomatic labels and proceeded in the direction of social interaction analysis and psychocultural phenomena. The physicalistic therapies, such as electro-shock and neurosurgery, seem to have worked with little theoretical justification against these scientific currents of the time.[1]

As late as twenty years ago the psychiatric literature was saturated with concepts that were oriented towards the nonsocial aspects of personality—man in relation to his instinctual past (Freud), his racial past (Jung). The psychological laboratories at the same time buzzed with experiments on achievement, intelligence, temperament, and learning processes of the individual animal or human being.

Today, theoretical events have taken a different turn. Man is viewed as a uniquely social being, always involved in crucial interactions with his family members, his contemporaries, his predecessors, and his society. All these factors are seen as influencing and being influenced by the individual. The new direction is marked by a series of new conceptual guide posts from communication theory, cultural anthropology, and neopsychoanalysis. We possess a new bibliography

[1] The research on neuropsychological relations accomplished at Tulane University under the direction of Robert G. Heath is a notable exception to this generalization.

of guide books pointing out the approaching scientific horizons and relating them to the past.

There is one concept which finds such wide and repeated expression in the current literature that it has taken on the debatable character of a motto. This is the term *interpersonal relations.* Introduced by the American psychiatrist Harry Stack Sullivan, it has become so popular that, at times, it appears destined to join those ill-fated concepts rendered meaningless by the frequency and pious generality of their usage.

The interpersonal theory is clearly a product of the converging theoretical trends of the time. It has many important implications for all the humanistic disciplines.

This book and the research which it summarizes take as a starting point the interpersonal dimension of personality. We shall trace in the following chapters a theory, a measurement methodology, and a psychological diagnostic system based primarily on interpersonal behavior. It seems appropriate, therefore, to take as the first question for consideration the definition of the basic term, *interpersonal.*

What Is Interpersonal Behavior?

Behavior which is related overtly, consciously, ethically, or symbolically to another human being (real, collective, or imagined) is interpersonal. This is a short but complex definition. Most of the succeeding pages will be devoted to its elaboration.

Let us consider some examples of human behavior in the light of this definition. The report from a reliable observer "George insulted his father" is clearly interpersonal. It tells how George related to his father, what he did to his father. The finding "George says he is a friendly person" comes from a different observation point, the subject's self-description, but is still clearly interpersonal. It tells how George perceives his motives toward other people. Also interpersonal is the inference made on the basis of dream or fantasy material "George dreams that his mother is protecting him." This refers to a fantasied relationship between the subject and another person. These descriptions of different aspects of the subject's behavior, which we call *protocol statements,* are the basic data on which we build a science of personality. They describe, at three different levels of observation, the subject's interpersonal relations.

Another dimension of personality is reflected in the statements "George acts impulsively," "George says he is not depressed," "George dreams of hatboxes." These descriptions are taken from the same three levels of observation—the outsider's report, self-report, and dreams—but they are not directly interpersonal. Impulsivity, opti-

mism, and a symbolic concern with containers have figured in certain personality theories and have some importance in the understanding of personality. Such descriptions are noninterpersonal because they do not refer to the subject's relationship to other people. They may be, and probably are, indirectly interpersonal. If we investigate further we might learn that George acts impulsively to impress others with his strength, that he says he is not depressed to prove that he does not need psychotherapy, and that he has a vague childhood memory of his mother bringing him lunch in a hatbox. The noninterpersonal thus becomes interpersonal; the personal characteristics take on a social meaning and reflect his relationships with others.

We shall subsequently see that much of the conceptualization in psychology and the nomenclature of psychiatry has been noninterpersonal. Terms such as *depressed*, *impulsive*, and *inhibited*, for example, refer to characteristics that possess maximum meaning when their interpersonal purpose is added. From the restricted and partisan interpersonal point of view, the functional value of such a popular diagnostic phrase as "the patient acts depressed" is really not very great until we add, overtly or implicitly, the social implication. We make such a phrase more meaningful when we designate the interpersonal context or the interpersonal impact of the action—"to get the psychiatrist's sympathy" or "to show his parents how badly he feels they have treated him."

Psychologists or psychiatrists who employ interpersonal concepts are generally characterized by an obsessive attention to the social implications of the subject's performance. They tend to view themselves as engaged in a complex relationship with the subject (or patient) and are particularly concerned with the social pressure which the subject is generating—the impression he is attempting to make upon them.

The interpersonal psychologist generally carries away from an interview or a testing session a diagnosis centering not on the patient's intelligence or his symptoms, but rather on the social machinery which the patient put into action during the session. In most clinical situations a numerical IQ index is of limited functional value. The clinician working from the interpersonal viewpoint would be more likely to stress not the patient's IQ, but the fact that "the patient acts in a wise manner and attempts to create the impression of intelligence," or, in another case, "the patient presents a façade of docile simplicity, acts as though he were uninformed and eager-to-be-taught."

Some Noninterpersonal Systems of Psychology

The interpersonal system presented in this book addresses itself to a narrow, limited slice of human behavior. There are many other facets

of human activity which have attracted the interest and energy of psychologists. In the Kaiser Foundation research we omit or ignore about nine-tenths of these activities and concentrate rather single-mindedly on one dimension—the interpersonal. We have restricted our theory to social behavior because we believe this to be the area of psychology which is most crucial and functionally important to human happiness and human survival. Our reasons for making this assertion will be detailed in a later section.

In restricting our studies to one source of data we fail to take into account hundreds of important variables which characterize the individual. Height, weight, age, appearance, and motoric patterns are all factors which have some value in predicting behavior. All the physiological aspects of the individual are left out of our system.

Sociological factors also contribute to the understanding of personality and carry clear-cut interpersonal implications. We have been unable, so far, to include these factors in our investigations.

Moreover, we have found it necessary to omit most of the variables which have had the highest priority for most psychologists—intelligence, interest patterns, political and cultural attitudes, and the variables of sensation and perception.

Academic and experimental psychology has traditionally focused on the noninterpersonal aspects of behavior. Psychophysical experiments, learning theories, and intelligence and aptitude studies have monopolized the majority of the chapters in psychological texts. These areas are left completely untreated in the system of personality presented in this book.

We are concerned, therefore, with a limited sector of the wide circle of human behavior. We concentrate simply on the way in which the individual deals with others—his actions, thoughts, fantasies, and values as they relate to others. In addition to restricting our attention to interpersonal activity, there is a further qualification. We cannot hope to include the entire range of the individual's social behavior, but will apply most of our energies to the task of understanding and predicting the subject's interpersonal behavior in one specific environmental context—his relationship to a psychiatric clinic.

Some Interpersonal Theories of Personality

We have seen that in the last twenty years the cultural and social factors of human nature have become the object of widespread scientific attention. Sociologists and anthropologists have been actively applying psychiatric concepts to their data with mixed results. Entire primitive societies have been diagnosed as paranoid, or typed in terms of the ways in which they feed their young.

At the same time, on the other side of the professional fence, several psychiatrists have assimilated the cultural into their thinking. Major revisions of orthodox Freudian concepts have developed. Three of the most successful of these personality theorists, Horney, Fromm, and Sullivan, have rejected the instinct theory and developed socially oriented structures of their own. A fourth, Erik H. Erikson, has constructed an impressive system integrating social phenomena into the Freudian libido theory.

Karen Horney began publishing in 1937 a series of important books in which she has developed a characterological approach to personality. She has described her dissatisfaction with the instinct theory and her own conceptual solutions in great detail. In her earliest work she contended that "neuroses are brought about by cultural factors"—which, more specifically, meant that neuroses are generated by disturbances in human relationships.

> In the years before I wrote *The Neurotic Personality* I pursued another line of research that followed logically from the earlier hypothesis. It revolved around the question as to what the driving forces are in neuroses. Freud had been the first to point out that these were compulsive drives. He regarded these drives as instinctual in nature, aimed at satisfaction and intolerance of frustration. Consequently he believed that they were not confined to neuroses *per se* but operated in all human beings. If, however, neuroses were an outgrowth of disturbed human relationships, this postulation could not possibly be valid. The concepts I arrived at on this score were, briefly, these. Compulsive drives are specifically neurotic; they are born of feelings of isolation, helplessness, fear, and hostility, and represent ways of coping with the world despite these feelings; they aim primarily not at satisfaction but at safety; their compulsive character is due to the anxiety lurking behind them. Two of these drives—neurotic cravings for affection and for power—stood out at first in clear relief and were presented in detail in *The Neurotic Personality*. (4, p. 11)

Later books presented increasingly sophisticated attempts to delineate the neurotic character structure. Horney has listed many types, trends, and conflicting attitudes to this end. All of these constructs concern the individual's reactions to others. At the time of her death, Horney's systematizing efforts were far from completed. The shifts in her flexible development have created the appearance of a brilliant disorganization. An over-all survey of her publications, however, reveals an internal consistency and a steady progress towards increasingly complex organizing principles.

Erich Fromm, like Horney, places the causative factor of neurosis in the family, which is seen as the basic "agency" of enculturation. Suppressive or hostile parents create the destructive feelings of powerlessness and isolation. Human relations and not instinctual pressure thus create personality. "Man's nature, his passions, and anxieties are a

cultural product; as a matter of fact man himself is the most important creation and achievement of the continuous human effort, the record of which we call history." (3, p. 11)

Fromm's theories of character are based on the ways in which the individual "relates" to his world. He has listed four neurotic mechanisms for "escaping" insecurity (masochism, sadism, destructiveness, and automaton conformity) and five character types (receptive, hoarding, marketing, exploitive, and productive). All of these are directly interpersonal. Fromm's major concern and greatest contribution lies not in the area of systematization, but rather in the philosophic backgrounds he has provided for the study of personality. The nineteenth century mechanistic pessimism of Freud, clearly inadequate for a science of human nature, has received a thoughtful, gentle, and imaginative revision by Erich Fromm.

Harry Stack Sullivan's most dramatic accomplishment was the assertion, which I believe he has demonstrated, that "psychiatry is the study of processes that involve or go on between people. The field of psychiatry is the field of interpersonal relations under any and all circumstances in which these relationships exist." (5, pp. 4–5) Sullivan's most valuable achievement is his demonstration of the "fabulously more complicated" nature of interpersonal actions and perceptions, and the introduction of observational methods and attitudes for making "objective contact with another individual."

The research and the theories presented in this book are based on the writings of Sullivan, and are in some sense an attempt to extend them. Although Sullivan's subtle and complex ideas do not summarize readily, a brief survey is in order.

The motive force of personality, for Sullivan as for Horney and Fromm, is the avoidance of anxiety. Anxiety, for all three, is an interpersonal phenomenon. For Horney it involves the feelings of helplessness and danger; for Fromm, isolation and weakness; for Sullivan, loss of self-esteem. Anxiety is interpersonal because it is rooted in the dreaded expectation of derogation and rejection by others (or by oneself). The human being is rarely or never free from some interpersonal tension; what he does or thinks is generally related to the estimation of others. For this reason the motivating principle of behavior is more accurately seen as "anxiety reduction"—the avoidance of the greater anxiety and the selection of the lesser anxiety. This is an important point to note, because, as we shall see when we deal with interpersonal reflexes, it helps explain some of the paradoxical self-punitive behaviors by means of which individuals appear to make themselves unhappy.

Personality is, according to Sullivan, the "relatively enduring pattern of recurring interpersonal situations which characterize a human

life." To understand a person is to have knowledge of the interpersonal techniques that he employs to avoid or minimize anxiety and of the consistent pattern of relationships that he integrates as a result of these techniques.

It is important to note that interpersonal behavior refers to private perceptions, conscious reports, symbolic and unwitting expressions, as well as to overt actions.

Another crucial difference between Sullivan's conceptions and the Freudian is worth comment. According to the orthodox Freudian, that which is warded off from consciousness is the instinctual impulse or its disturbing derivatives. According to Sullivan, those things which are selectively kept from awareness are interpersonal processes, or potentialities, or interpersonal feelings which are anxiety-arousing.

The self-dynamism is created by anxiety, being the system of anxiety-diminishing behavior characteristic of the developing individual. Sullivan has distinguished three modes of experience which have important implications: the prototaxic, undifferentiated, unverbalized experiences of early infancy; the parataxic, which includes private, unwitting personifications of the self or eidetic others; and the syntaxic. The latter mode is defined by the "extent that observation, analysis, and the eduction of relations is subjected to *consensual validation* 'with others.' . . ." Consensual validation, a concept with rich empirical meaning, is the "degree of approximate agreement with a significant other person or persons which permits fairly exact communication by speech or otherwise, and the drawing of generally useful inferences about the action and thought of the other." (6, p. 177) When two people in an interaction situation are consensually agreed on the basic premises upon which the relationship rests, and when they concur in their pertinent perceptions of self and each other, then they are communicating in the syntaxic mode. This kind of honesty between persons is not a common phenomenon. Its experience can be unbearably painful due to the anxiety it evokes.

The discussion so far has carried us with hazardous speed and brevity through those conceptions of Harry Stack Sullivan which are most appropriate to the purposes of this volume. We leave without any description a host of strikingly original theories—on interview tactics, on obsessional and schizophrenic states, on the six epochs of personality development, on dissociative and selective inattention, to name a few.

The weakest links in Sullivan's strong conceptual chain are the systematic. His publications up to the present (including posthumous volumes) have broken new theoretical ground that has not been sown or harvested. He presents an approach but not a methodology. He

convincingly buries the much-berated remains of descriptive, Kraepelinian, and negatively-value-toned psychiatry, but provides no substitute classification system. The carefully worked-out categories he presented—experience modes, developmental epochs, self-dynamisms—are far from the minimum required for a science of personality.

Sullivan provides an attitude (humility) and an approach (participant observation), but not a methodology for the science to which he was dedicated. His formal notational structure is disappointingly disorganized and incomplete.

The Theories of Erik H. Erikson

In the preceding section we have considered the contributions of three personality theorists who have abandoned the libido conception and espoused a social or interpersonal point of view. Horney, Fromm, and Sullivan do not deny the importance of sexual and biological factors. Sullivan, for example, divides human performance into two categories based on the "end states" or goals which are involved. The first involves "satisfactions," by which Sullivan denotes bodily activities. The second end state is "security," which refers to the interpersonal or cultural responses. Having paid his respects to the biological facet of human behavior, Sullivan went on to focus almost exclusively on security operations and the social dimension of behavior.

In contrast to the antilibido theorists mentioned above, there is a fourth social system of personality which attempts to develop ego, cultural, and interpersonal conceptions within the basic framework of the Freudian psychosexual theory. This is the work of Erik H. Erikson. (1)

Erikson includes in his systematic writings three personality processes, the somatic, the ego, and the societal. He demonstrates (by means of a brilliant marshaling of clinical material) that a human event cannot be understood unless the *relativity* of these three factors is grasped.

> We study individual human crises by becoming therapeutically involved in them. In doing so, we find that the three processes mentioned are three aspects of one process—i.e., human life, both words being equally emphasized. Somatic tension, individual anxiety, and group panic, then, are only different ways in which human anxiety presents itself to different methods of investigation. . . . As we review each relevant item in a given case, we cannot escape the conviction that the meaning of an item which may be "located" in one of the three processes is co-determined by its meaning in the other two. An item in one process gains relevance by giving significance to and receiving significance from items in the others. Gradually, I hope, we may find better words for this *relativity in human existence*—as we shall tentatively call what we wish to demonstrate. (1, p. 33)

Erikson has made the most sophisticated and successful attempt to integrate historical, sociological, anthropological, and biological data into a personality system. He takes for his model of individual character structure the Freudian psychosexual theory to which he has added an interpersonal terminology. His commitment to the biology of the libido theory is stated quite directly. "It will seem to some that I am abandoning this point of view [i.e., the importance of interpersonal regulation patterns] as I now proceed to review the whole field of what Freud called pregenital stages and erotogenic zones in childhood *and attempt to build a bridge from clinical experience to observations on societies.* For I will again speak of biologically given potentialities which develop with the child's organism. I do not think that psychoanalysis can remain a workable system of inquiry without its basic biological formulations, much as they may need reconsideration." (1, p. 65)

Erikson has expanded and "socialized" the Freudian timetable of psychosexual adjustment by means of two ingenious systematic devices—his conceptions of zones, modes, and modalities and his theory of the eight stages of man's psychological development.

Erikson focuses on three major zones of psychosexual activity—oral, anal, and genital. He then defines five modes of approach or basic interpersonal vectors which can be expressed by any organ zone. These are incorporative 1 (sucking), incorporative 2 (biting), retentive, eliminative, and intrusive. A matrix of the combination of zones and modes provides a neat device for classifying the fixations, regressions, and sequences of normal development.

An even more original conversion of Freudian developmental theory to interpersonal language is accomplished by Erikson by means of his eight stages of human emotional growth. This is a "list of ego qualities—criteria by which the individual demonstrates that his ego, at a given stage, is strong enough to integrate the timetable of the organism with the structure of social institutions." Erikson holds that the individual at each sequential stage of life meets a nuclear conflict, the solution for which "is based on the integration of the earlier ones."

The eight nuclear conflicts according to Erikson are:

Stage of Life Cycle	*Nuclear Conflict*
Oral Sensory	Trust vs. Mistrust
Muscular–Anal	Autonomy vs. Shame, Doubt
Locomotor–Genital	Initiative vs. Guilt
Latency	Industry vs. Inferiority
Puberty and Adolescence	Identity vs. Role Diffusion
Young Adulthood	Intimacy vs. Isolation
Adulthood	Generativity vs. Stagnation
Maturity	Integrity vs. Disgust, Despair

Erikson's commitment to an interpersonal and cultural point of view stands out clearly in this list of ego qualities. The extraordinary power and significance of Erikson's work is this: he has developed a social conception of human nature which certainly equals in complexity those of Fromm and Horney—and he has done it within the broad framework of the Freudian libido theory. He seems to have succeeded in his attempt to build a bridge between psychosexual theory and social behavior, and has additionally erected a system which is eminently heuristic.

There is therefore considerable justification for considering Erikson as the first major psychoanalytic systematist since Freud. He has, it must be noted, surpassed Sullivan on his own home ground by presenting a developmental timetable which lists sixteen interpersonal resolutions. This provides us with an impressive list of interpersonal variables lacking in the writings of the less systematic Sullivan.

The interpersonal system of personality to be presented in this book has leaned heavily upon the conceptions of Erik H. Erikson. Our classification of interpersonal behavior bears the unmistakable mark of Erikson's theory. We have been able to utilize only a fragment of his system. This is because Erikson's writings range deep and wide—deep into childhood and wide into society. Our own purpose and efforts are much more restricted since we have attempted simply to develop an objective, functional system for predicting the behavior of adult patients in the psychiatric clinic.

Interpersonal Behavior Defines the Most Important Dimension of Personality

In the preceding sections we have presented a definition of interpersonal behavior and have compared several approaches to human nature in the light of their social orientations. The assertion was made that the interpersonal can from this point of view be considered the most crucial and functionally important dimension of personality.

First, from the broader theoretical frame of reference, interpersonal behavior is crucial to the survival of the human being. From a second (and much more parochial) point of view, interpersonal behavior is the aspect of personality that is most functionally relevant to the clinician. Some justification for the first of these assertions will be discussed in the next section. The usefulness of an interpersonal theory in clinical practice will be considered in Chapter 5.

Interpersonal Behavior and Biological Survival

From the standpoint of human survival, social role and social adjustment comprise the most important dimension of personality. This

is because of the unique biological and cultural aspects of human development and maturity.

One of the major differences between man and the other animal species is his long and helpless infancy. Depending on the complexity of the culture, it takes from 12 to 25 years for a human being to attain developmental maturity. This long period of childhood and adolescence involves a dependence on other human beings for nourishment, shelter, and security. Many animal species, on the contrary, are ready to undertake complete responsibility for their own survival at birth, or shortly thereafter. In these cases instinctual methods of locomotion, food collection, and self-protection take over immediately. Rigidly built-in patterns of response are vital to their early self-sufficiency. Automatic physiological responses are the key to life for these infrahuman organisms.

The case of man is quite different. The human infant has limited physical capacity and few automatic behavior sequences for dealing directly with the physical environment. From the moment of birth, survival depends on the adequacy of interpersonal relationships. The water, warmth, and milk upon which the infant's life depends come from others. These primitive, basic transactions which the neonate carries on with others are, we are told, not rigidly fixed patterns. A variety of early parental response exists, and this is matched by a variation in neonate behavior. Several experts in this field (Sullivan, Klein, Erikson, Ribble, Spitz) have claimed that the roots of personality are to be found in the earliest mother-child interactions. This claim is not surprising when we recall that a raw, intense, basic anxiety (concerned with the maintenance of life itself) may be felt by the neonate. And this anxiety is dealt with (partially or completely, carelessly or lovingly, calmly or nervously) by the mothering-one. The earliest kind of survival anxiety is, therefore, handled by interpersonal, social responses.

From the standpoint of physiology the human infant is not much different from any young mammal. From the standpoint of personality psychology, however, the human being at birth is an extraordinarily plastic, germinal nucleus with infinite potentialities for eventual differentiation. It might be said that any neonate is a potential president, priest, poet, or psychotic. Personality psychology is concerned with the events and behaviors which determine the emotional and social development of the individual. The most important factors which account for the wide varieties of behavior characteristic of the human being are the interpersonal security operations which he develops and the social relationships (real and fantasied) which he integrates with others.

We have pointed to the crucial influence of the earliest social transactions between mother and child—crucial because of the survival anxiety involved and because of the complete dependence of the infant.

As the child grows, the primacy of interpersonal relationships does not lessen greatly. A seven-year-old child has developed many motoric patterns for self-protection, but on the hypothetical desert island or in any societal context we cannot credit him with survival self-sufficiency.

The human being maintains existence by virtue of the long period of parental protection during which he assimilates the complicated cultural wisdom necessary for survival. This process of slow, and often painful, learning is intensely interpersonal.

Even at maturity survival rests upon successful interpersonal patterns. The mutual dependence of mankind is inevitable. Whether we exist in a primitive tribe, a dictatorship, or an industrial democracy, the key to human life lies in the adequacy of social interaction. Even the rare test case of a hermit falls within the limits of this generalization, since this adjustment technique always involves intense and often bitter "withdrawal" from others, and is one pattern of interpersonal reactivity. The extent to which we automatically and implicitly demonstrate patterns of cooperation and submission to social demands —even in the most democratic society—is quite striking. Failure to do so invites such real or fantasied threats to life that we automatically commit ourselves in countless ways to the interpersonal pressure of parents, societies, and contemporaries.

Anxiety Motivates Interpersonal Behavior

The preceding section is intended to justify the statement that interpersonal behavior has a basic survival function. The fear of interpersonal disaster is rooted in a fear of destruction or abandonment. The organism has hundreds of physiological functions by which destruction is warded off and life preserved. The individual develops, in addition, numerous emotional responses which, in their origins, are concerned with survival.

The psychological expression of the survival drive of evolution theory is anxiety. Primal anxiety is the fear of abandonment.[2] As the child begins to develop, this becomes a fear of rejection and social disapproval. Mankind's social interdependence means that extreme

[2] In the first version of this manuscript this sentence read, "Primal anxiety is the fear of death." The revision was made at the suggestion of Harvey Powelson, M.D., who pointed out that *death* is a sophisticated, complex concept which an infant or young child has not mastered.

derogation on the part of crucial others can lead to destruction. The behaviors by which the child avoids derogation are called security operations. They assure him of the approval and social security which reduce his anxiety.

As the individual develops, further complications ensue. Self-esteem becomes a factor which is equal to, or greater than, the overt esteem of others.[3]

The role of anxiety in the development of human personality is central, and it is intricate beyond our understanding. Although rooted genetically in the fear of death, anxiety (i.e., the fear of disapproval) is clearly stronger in the case of the adult than the fear of death. There are countless examples of human beings choosing to face and accept destruction rather than face anxiety and the loss of self-esteem. Suicide is one of many such examples.

Another complication which must be considered in understanding the effects of anxiety involves the multilevel organization of behaviors for warding off anxiety. A large percentage of any population, for example, develops security operations which entail overt self-effacement, self-derogation, and the provocation of actual contempt and disapproval from others. These overt self-derogations, which seem to contradict our theory of anxiety, can be understood by means of a multilevel analysis. They are inevitably related to private feelings of uniqueness or secret consolations. They serve to protect inner feelings of pride and self-enhancement.

This book and the system of personality which it describes is concerned with a multilevel investigation of human security operations. We have taken as our task the definition, classification, and measurement of interpersonal behavior (at several levels). We view the interpersonal behavior of an individual as the machinery by means of which he wards off anxiety and maintains a multilevel balance of self-enhancement.

The conceptual model of personality which we are developing exposes one area of human behavior to study. This is the interpersonal dimension. The theoretical system is based on one assumption about the motivation of emotional behavior. This has been formalized as follows:

FIRST WORKING PRINCIPLE: *Personality is the multilevel pattern of interpersonal responses (overt, conscious, or private) expressed by the individual. Interpersonal behavior is aimed at reducing anxiety. All*

[3] The complexity of the processes of identification and introjection make this comparison redundant and probably meaningless. There is good reason to believe that self-esteem is usually or always based on values which are taken from others. Thus self-esteem can be considered an indirect form of approval of crucial others.

the social, emotional, interpersonal activities of an individual can be understood as attempts to avoid anxiety or to establish and maintain self-esteem.

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2

Adjustment-Maladjustment Factors in Personality Theory

It is the theme of this chapter that personality theories should hold for adjustive and maladjustive behaviors, that normality and abnormality should be defined as different points on the same measurement continuum, and that the conceptual terminology of personality should therefore include the entire adjustive range of human activity. Few theories do this. Most are oriented toward abnormal or neurotic behaviors. Most diagnostic systems have few terms for conceptualizing adaptive behavior, which is described in vague generalities or in terms of the absence of pathology.

This is an unfortunate state of affairs. It reflects an undeliberate but significant depreciation of human nature. In addition, this *pathology error* tends to distort our theories of personality by placing a disproportionate emphasis on certain limited types of maladjustment.

A science of malfunction cannot precede a science of function. Therapeutic tactics can break new ground, but scientific and theoretic progress depends upon the development of the principles of normal adjustment. The fact that psychiatric theories of personality have been based on clinical experiences has led to some curiously one-sided conceptualizations. Psychiatry, however, cannot be wholly blamed for these restrictions, which, as we shall see, spring from a marked asymmetry in the ethical evaluations of varying interpersonal themes in our Western culture.

Before approaching the definitions of adjustment-maladjustment we shall review psychiatry's overemphasis on the abnormal, and we shall consider some causes and implications of this pathology error.

Psychiatric Theories Are Oriented Towards Pathology

A history of man's conception of his own nature has yet to be written. When our systematic knowledge of human expressive be-

havior is more advanced, it will be possible to study the literary and historical documents of the past, and to determine the expressed and implied views of personality that determined the behavior of our ancestors. One tentative generalization—basic to the theory of this book—may be helpful in surveying the changing conceptions of human nature. This concerns the Locus of Responsibility for human behavior. There seems to be a consistent tendency in the development of psychological knowledge to move the causative factor of human behavior from external to internal forces. This is clearly reflected in the changes in the theoretical explanations of abnormal or maladjustive behavior.

We are told that success or failure appeared, to the ancients, to be controlled by the immutable and mysterious powers of nature. Sun, seed, and storm were fearful forces—completely inexplicable. Man's survival responses appeared by comparison quite meaningless. The shift of causative principles to anthropomorphic gods made human behavior somewhat more important. The notion that man can move the gods by propitiation, obedience, or defiance considerably humanizes the causative sequence.

This conception which lasted from the Greek civilization through to the nineteenth century (and which still is maintained by a large majority of individuals living today) defines personality aberration as a religious phenomenon. Maladjustment is a mark of omnipotent intervention, generally indicating a sinful nature. The maladjusted person is isolated, overtly punished, or covertly rejected. The error is man's and the power is the god's.

The theories of descriptive psychiatry which emphasized constitutional morbidity, although they had the ring of scientific objectivity, were still very crude conceptions. They were abysmally inferior to the insights of the artistic geniuses who preceded them by several centuries. Shakespeare, for example, progressed much further from the Greek mythology than the average hospital psychiatrist of the early 1900's. On the other hand, in the strictest sense of dramatic motivation, Oedipus was a morbidly predisposed type—since no choice is given him at any point to reverse his awful destiny. This type of psychological explanation is quite congenial to pre-Freudian psychiatry. Change a few mythological terms and Oedipus is an acceptable case history from the textbook of the nineteenth century alienist. When we compare this predestined helplessness with the self-imposed conflicts of Shakespeare's characters the descriptive psychiatrist comes off badly. Although Elizabethan theories of human destiny involved chance and fortuitous influences (the wheel of fate), still the reader is impressed by the implication that the poet's heroes

court their tragic ends because of *their own* greed, ambition, indecision, and shallowness. The causative agency has moved from the external and immovable force to the partial responsibility of the hero for his own self-created destiny.

The notion that human nature and the individual's fate are determined by his own (conscious or unconscious) decisions and solutions is brilliantly illustrated by Marcel Proust. In *Remembrance of Things Past* he describes how his hero deliberately trains and provokes his parents to accept him as a neurotic child. In the following episode he literally creates his own maladjustment and develops the weak and asocial role he is to maintain in his future life. His parents agree, " 'It is his nerves . . .' . And thus for the first time my unhappiness was regarded no longer as a fault for which I must be punished, but as an involuntary evil which has been officially recognized, a nervous condition for which I was in no way responsible: I had the consolation that I need no longer mingle apprehensive scruples with the bitterness of my tears; I could weep henceforth without sin."

The narrator recognizes, however, that his neurosis is not "involuntary," but rather a purposive, victorious interpersonal maneuver. He has unconsciously selected nervousness as a security operation. The narrator then goes on to say, "I ought then to be happy; I was not. It struck me that my mother had just made a first concession which must have been painful to her, that it was a first step down from the ideal she had formed for me, and that for the first time she, with all her courage, had to confess herself beaten. It struck me that if I had just scored a victory it was over her; that I had succeeded, as sickness or sorrow or age might have succeeded, in relaxing her will, in altering her judgment; that this evening opened a new era, must remain a black date in the calendar." (4, p. 49)

Freudian Theory of Normality

With the Freudian theory, psychology begins to catch up with the intuitions of literature. Man's character, his responses and solutions to the overwhelming conflicts of life are brought into focus. While man has a choice of reactions which bring relative amounts of temporary security, the balance, according to Freud, is still on the side of the native, instinctual endowment. The doctrine of instincts emphasizes the inevitable pressure of drives external to the ego. In early psychoanalytic theory it is libidinal drive that is basic, inborn, constant, and, in the final sense, victorious. The adaptive forces are acquired, inconstant, variable, and, in the final sense, secondary. In fact, the ego functions, defense mechanisms, and character traits were sometimes interpreted as neurotic solutions.

By building his logical notational structure on the "id" instincts, Freud was making a formal decision, and not an empirical discovery. Impressed by the new insights he obtained into the antisocial impulses, it was natural for Freud to base his theory on that aspect of human motivation. It is generally accepted that later developments in psychoanalysis have reversed this trend, and have placed more emphasis on the ego, studying its structure, function, and the multiplex variety of its processes. But it is also commonly known that early psychoanalytic terminology tends to lack terms for describing adjustive behavior and normal processes. The conceptual contributions of Erikson have competently filled in this gap in the psychoanalytic nosology.

The psychoanalytic theory of personality, which is by far the most complete and complex theory, is based on the statistically narrow, neurotic extreme of the general population in two or three Occidental countries. As we shall see subsequently, there is good evidence to suggest that early psychiatric and psychoanalytic theory was based on less than one half of the range of this maladjustive extreme, and that perhaps 50 per cent of neurotic solutions remained largely undefined.

The curious phenomenon of a massive theoretical structure erected on an emaciated sample of subjects is, I believe, due to two basic factors, one logical and one empirical. Freud's formal choice in emphasizing the destructive strivings is historically comprehensible, and no detraction from his creative genius.

The empirical factor, as I have suggested, refers to the narrow range of individuals whose neurosis is such as to lead them to submit to the singular and rather implausible process of psychoanalysis (cf. Chapter 12).

Jung's Emphasis on Adaptive Behavior

The Jungian school of analytic psychology produced several important revisions of Freudian concepts. Most of its unique contributions are refinements and extensions of Freudian theory. To the extent that any cognitive issue was involved, we can say that the Zurich group split off from Vienna when Jung rejected the narrow sexual interpretation of libidinal energy. By broadening the meaning of this basic impulse, Jung and his followers have made it general and vague, and thus relegated it to a secondary theoretical position. This indirect shelving of the libido theory can be taken as an unpremeditated, but vital, aspect of the Jungian position. Other revisions pertinent to this discussion include theories of functions, neurosis, and unconscious motivation.

The Jungian functions—extroversion, intuition, thinking, etc.—are seen as important, but not necessarily negative, psychological mechanisms. They are pathological only when rigidly misused or when completely repressed. For the most part, when a Jungian diagnostician calls the subject "introverted" he is not making a value judgment; he implies only that this is an important way in which the patient handles experience and its conflicts, and it may or may not be necessary to modify its use.

It follows, then, that the Jungians do not see character distortions as pathological fixations or regressions to inevitable infantile stages. They describe neurosis as a partial solution to life's dilemmas—a constructive mobilizing of "psychic" resources against real or imagined threats. They might say of the neurotic pattern, "This is a good try, perhaps the best you could do under those circumstances. Now let's see what the results of these solutions have been and what other possibilities for resolution we can discover."

This approach has much to recommend it. It is very congenial to the current medical conception which defines disease, not as an unfortunate falling ill, but as a complicated interaction between one network of adaptive responses and another network of threatening events.

Another, and perhaps the greatest, advantage of the Jungian system is the conception of unconscious motivations as valuable, undiscovered potentials of the self, rather than as destructive impulses. Bateson has appraised the Jungian viewpoint as more consistent with the principles of communication theory. He points out that

> the Freudian ambition to substitute ego for id or to include the id within the scope of the ego, sounds to Jungians like advocating manipulative and conscious control of the foreign body. In reply to this they would urge merely the acceptance—even the joyful acceptance—of the fact that the foreign body though always and inevitably unconscious is really a part of the self and the self a part of it—the collective unconscious being imagined to be in some sense greater than the self. (5, p. 264)

With this background it becomes clear that the Jungian theory, although based on and indebted to the work of Freud, has made certain advances toward a balanced conception of normality-abnormality factors. Shifting the stress from infantile strivings to the selecting and adapting functions of response helps to free psychology from fatalistic themes which have limited man's view of human nature from Sophocles' time through Freud's.

Jungian theories have contributed, often indirectly, to four promising notions. First they bring us closer to the development of a normality-abnormality continuum, which makes neurosis not a quali-

tatively different phenomenon. They help us see the interaction between biological-cultural pressures and the adaptive-maladaptive responses of the individual. They emphasize the "circular or reticulate" equilibrium of different levels of personality rather than the one-sided organization for warding off unconscious motivations. Finally, they are, perhaps, the first to introduce the far-reaching idea that unconscious or repressed motives can be positive, constructive potentials, and are not necessarily negative.

Many of these doctrines were only implicit in Jung's writings, and credit for their informal, undramatic development must be assigned to certain American analytic psychiatrists, in particular, Joseph Wheelwright and Joseph Henderson.

Horney and Fromm on Normality

This general tendency to focus upon adjustive behavior has been given articulate expression by psychiatric systemists who have emphasized the cultural dimension of personality. When Horney and Fromm substitute cultural factors for instinctual pressure in the causative formula, they bring about drastic revision in attitudes toward mental health and disease. In the first place, the sexual and aggressive instincts—defined by Freud as universal, immutable, and antisocial—tend to taint all men with a new form of original sin. The culture concept is much more flexible. It gives man, or some men, a halfway chance because of the wide variation in social environments and cultural pressures.

Thus the diagnostician's causative questions become: "What were the set of biological, familial, social, and cultural pressures which this patient faced, and what was the particular network of responses by which he dealt with them?" The issue of normality-abnormality takes on new meaning in this context. A survey of the publications of Fromm or Horney will reveal the extent to which these authors are concerned with the individual's attempts to solve his conflicts. We have in the previous chapter cited a partial list of some dozen mechanisms, escapes, and trends described by these two theorists. Over and over again they emphasize the response of the patient to the environment, and his interactions with it. Their interest in pathology is always linked to the underlying notion that neurosis is acquired by and through the individual's reactions to social stress, and the subsidiary idea that it can be "cured" by shifting one's reactions to stress in the future.

Basic and implicit to the theories of both is the theme that maladjustment is different in degree, and not in kind, from the so-called norm. Fromm states this clearly,

The phenomena which we observe in the neurotic person are in principle not different from those we find in the normal. They are only more accentuated, clear-cut, and frequently more accessible to the awareness of the neurotic person than they are in the normal who is not aware of any personal problem which warrants study. (1, p. 17)

Sullivan and the Concept of Normality

Within the framework of a brief historical review we have been selecting several themes which comprise the message of this chapter. These include the qualitative similarity of normality-abnormality, the locus of responsibility assigned to the individual's behavior, rather than to fatalistic forces, and the necessity to take into account the multilevel nature of human potentialities. These concepts, which are implicit in the development of psychoanalytic theory during the last fifty years, appear over and over again in the writings of Sullivan. This theorist, we recall, holds that the self is formed through the child's sensitivity to approval and disapproval. If we accept this notion that personality is determined by interpersonal anxiety we have closed the qualitative gap between normal and abnormal. "*Everything* that can be found in mental disorder can be found in anyone, but the accent, the prominence, the misuse, of that which is found in the mental patient, is more or less characteristic." (3, p. 77) With this remark Sullivan advances the concept of the continuity of normal and abnormal human behavior which developed from the original Jungian protest. Listing neurotic and normal behavior along a relativistic continuum is a humanistic trend, which results in changing techniques in psychotherapy. Moreover, it lends itself more directly to scientific procedures, since probability laws become considerably more feasible. The pathology error in psychiatric thinking led to theorems that were based on neurotic behavior, and which had little to say about normal functioning. By concentrating on the processes of adaptation in their successful and unsuccessful forms the stage is set for many new personality systems which will hold for all human behavior.

Emphasis on Adaptive Responses Leads to a Neutral Conception of Human Nature

To insist that psychology focus on man's executive, adaptive reactions—in their adjustive flexibility as well as their maladjustive extreme—is not to argue for a bright-eyed optimistic view of the human situation. In many ways it is much kinder to inform a fellow human being that his misery or failure is due to divine direction, inherited disposition, or biological destiny. We remember that Sophocles, while plunging Oedipus into the depth of despair, never forced him to express man's most poignant lament, "I could have done

differently." His fate was always in the hands of the gods. The responsibility for human destiny is thereby transferred to external forces. This view relieves man of the obligation to effect change, which is assigned to omnipotent powers among whom later generations have included the physician. This is probably the easiest and most comfortable conception of human nature.

When we interpret adjustment in terms of the individual's own responses, rigid solutions, and escape mechanisms, we present our fellow-sufferers with an ambiguous gift. Two rather staggering implications accompany this conception. Neither are particularly optimistic. The first is, "You must accept the blame or credit for your present situation; you, and not your rejecting parents, your race, your instinctual heritage, your drunken husband, but your own pattern of repetitive and self-limiting responses created it." To this grim frankness we must add the corollary, "To you, therefore, is given the power to change your situation. . . . it is impossible and unnecessary to change your childhood, the society in which you live, your skin color, your biological make-up, or your spouse—what is required is a change in your inaccurate perceptions and rigid reactions."

When we replace immutable external forces with self-determinism, we invite the individual to accept a most lonely and frightening power which, as Fromm has pointed out, none of us are well trained to assume. This is, of course, neither an optimistic nor a pessimistic point of view, being rather the neutral realistic statement of the reciprocal principles of social interaction and self-determination.

Symptom and Character

The changing approaches to personality just described have resulted in an additional clarifying abstraction which is very pertinent to the conception of neurosis. This is the distinction between *symptom* and *character*.

As used in this context, the term *character* refers to the personality —the durable, multiple-level pattern of interpersonal tendencies organized into stable or unstable equilibria. This complex organization of perception and action is a logical notational structure by which we conceptualize the anxiety-reducing operations of the individual. It is the theoretical and linguistic device by which we summarize our knowledge of a human being. The character structure, as the sum total of an individual's interpersonal behavior, is the psychologist's shorthand for the social human being.

A *symptom*, as succinctly defined by Masserman (2, p. 298), is any "overt manifestation of a disease or behavior disorder." It is one aspect of the unified network of variables that make up personality,

and an important aspect in that it indicates an imbalance or malfunction in the character structure. A symptom not only tells us that something is distorted in the personality, but in the nature of its specificity often suggests what kind of a distortion exists. Regardless of how centrally painful psychiatric symptoms may be to the patient or to his intimates, their meaning, function, and treatment must be viewed as one set of factors related to many others in the personality organization.

To illustrate the distinction between symptom and character, let us pose the question, what do we mean by neurosis? Psychiatric textbooks define neurosis in terms of repetitive, anxiety-driven behavior based on internal conflict, and manifesting certain symptomatic expressions. This is a broad, inclusive, dictionary-type definition, and a pretty good one. It emphasizes not only the external appearance of neurosis—the symptoms—but also the underlying character distortions. Unhappily when the nonanalytic psychiatrist takes off his Sunday-best terminology and lists his workday operating diagnostic concepts, this nice balance is lost. Most, if not all, of the commonly used psychiatric categories—schizoid, depressive, psychopathic, psychosomatic—are symptom-oriented. They are based on certain external signs of unsuccessful adaption. In practice, an individual is diagnosed as neurotic if he manifests the so-called psychiatric symptoms which are restricted to a certain range of social inefficiencies. Most patients come to the psychiatric clinic not expressing dissatisfaction with their character, but requesting relief from symptoms. The attention of the patient and most preanalytic therapists is naturally directed to the painful, and often terrifying external manifestations of psychiatric distress. This symptom orientation supplies another reason why psychiatry and the personality theories it has produced have taken on the negativistic, neurosis-bound cast which we have called the pathology error.

The attempt to develop personality theories in the atmosphere of the consulting room and clinic has resulted in still another interesting limitation. The second half of this compound fallacy is caused by the fact that (until the last decade), of all neurotic character types, only about one half came in any frequency to seek psychotherapeutic help. We can suspect that about 50 per cent of individuals with marked character distortions (i.e., one half of the diagnostic continuum) did not show up in large numbers in the nineteenth century psychiatric office because the very essence of their imbalance tended to push them away from dependence, self-revelation, and conforming cooperation.

The diagnostic chapters of this book will consider this interesting phenomenon in some detail. It is pertinent to the argument here to

point out that a large percentage of the maladjusted population has traditionally received little psychiatric attention. They were not studied because they did not come for psychiatric help. They did not seek therapeutic assistance because the core of their anxiety-reducing operations was a compulsive maintenance of power, independence, competitiveness, or defiance—interpersonal techniques which preclude, under ordinary circumstances, the role of a psychiatric patient.

Working Principle II: Adjustive-Maladjustive Personality Variables

Thus, our personality theories have not only been lopsided in the direction of maladjusted rather than normal subjects, but also limited by overemphasis on a narrow fragment of the over-all neurotic population. We can now present the second principle upon which the interpersonal system is based.

SECOND WORKING PRINCIPLE: *The variables of a personality system should be designed to measure—on the same continuum—the normal, adjustive aspects of behavior as well as abnormal or pathological extremes.*

In validating a system of personality, the procedures of data collection should include samples of both adjusted and maladjusted subjects. Among the maladjusted there should be proportionate empirical attention to those subjects whose anxiety is lessened by rushing-into-a-psychiatric-clinic as well as those whose anxiety is diminished by a rushing-away-from-the-interpersonal-implications-of-the-psychotherapeutic-situation.

By basing their conceptions on the human character structure, rather than on a fractional segment of symptoms, Erikson, Horney, Fromm, and Sullivan have doubled the range of personality types. We learn that many apparently successful and socially approved behavior extremes—the driving competitor, the overambitious leader, the overpopular hero—can be based on imbalanced and neurotic character structures. It is easy to add the corollary that many phenomena classically considered deeply pathological—mild autistic withdrawals, moderate unconventionality, moderate depressed obsessiveness—are not severe imbalances but constructive, healthy, and perfectly acceptable methods of warding off anxiety.

Effect of Cultural Values on Theories of Normality

Fromm speaks in this connection of the difference between personal and social maladjustment. Social efficiency manifested by public esteem, high income, and feverish productivity may give the appear-

ance of healthy adjustment at the expense of disequilibrium and internal distortion. Social inefficiency, defined in terms of low income, nonconformity, modest station, social introversion, and relaxed ambition does not always indicate unhappiness or psychic disturbance. Poets have known this for some centuries.

The basic values of the American middle class, which insidiously permeate all of its members, exert their influence on contemporary psychiatric theories. It is very easy to identify normality with conventionality or optimistic, active, responsible independence; and neurosis with nonconformity or pessimistic, inactive sensitivity.

The definition of adjustment is thus complicated by the inevitable pressure of value systems: Is it more "normal" to express constructive, conjunctive, conventional affiliative feelings? Is it more "abnormal" to manifest distrustful, hostile, rebellious behavior?

The personality theorist need not base his definition on cultural values, but it is certainly necessary to take into account the social and ethical esteem which attaches to certain popular security operations.

There are two issues which must be faced—a quantitative and a qualitative consideration of adjustment.

Quantitative Definition of Adjustment

This book is presenting a system for diagnosing personality which strives to be objective and operational. This commits us to a quantitative definition of maladjustment. We set up continua for measuring or classifying interpersonal behavior in terms of several indices. Normality-abnormality is defined in terms of these indices.

The first of these quantitative scales concerns consistent moderation versus intensity at any one level of behavior. The former is considered adjustive, the second maladjustive.

The second categorization concerns flexibility versus rigidity at any one level of behavior. The former is considered adjustive, the latter maladjustive.

A third quantitative index of normality involves the stability or oscillation among different levels of personality. Extreme conflict (oscillation) among levels is viewed as maladjustive. So is extreme interlevel rigidity, i.e., the same interpersonal operations repeated at all levels. Stable or balanced interlevel patterns are seen as adjustive.

A fourth (and less clear-cut) definition of normality involves measurements of accuracy and appropriateness. If behavior is inappropriate, if perceptions are inaccurate, then maladjustment is indicated.

The methodology and specific application of these quantitative indices will be described in later sections of this book.

Qualitative Definition of Adjustment

A second approach to the definition of adjustment and maladjustment involves a qualitative assessment of behavior. Here we do not ask "how much?" or "how rigid?" or "how accurate?" but concentrate on *what kind* of interpersonal behavior.

The qualitative definition of normality is inextricably rooted in value judgments and does not appear to be useful in developing an objective diagnostic system. The quantitative concept of adjustment is based on the notion of personal adjustment. How balanced, accurate, adaptable are the security operations? How successful are they in warding off anxiety? The qualitative concept is based on social adjustment—conformity to cultural stereotypes as to what is normal.

Let us grant that no human being is perfectly balanced, and that everyone has developed modes of dealing with anxiety which emphasize certain interpersonal behaviors and minimize others. The qualitative question then becomes: Are there socially preferred kinds of security operations? Are there certain modes of response which are intrinsically better than others?

Is conventionality or loving trust, for example, intrinsically more adjusted than bitter rebellion?

There is no answer to these questions. This is a cultural, ethical issue. The neutral position of the scientist (which of course is an ideal and never an actuality) can be preserved by accepting explicitly quantitative definitions of adjustment and avoiding (as far as it is possible) the qualitative.

By way of illustration, let us consider two patients, both of whom have intense underlying feelings of despair and a long history of deprivation and derogation. One patient reacts to these inner feelings and experiences by means of a rigid conventionality and conformity to duty. The second patient reacts to the same inner feelings and the same unhappy history by means of a rigid rebellion and bitter rejection of conventional behavior.

Assuming the rigidity and intensity of the two security operations to be equal, is one more adjustive than the other? A quantitative definition would hold that there is no difference.

A qualitative definition might tend to consider one more normal than the other. Certainly, most cultural, ethical values would prefer the former conforming, cooperative operations and disapprove of the latter. But from the standpoint of the individual and his quest for security it will be seen that both may achieve the same amount of self-esteem and suffer from the same amount of conflict. They may be equally successful in warding off anxiety.

Large and diverse samples of subjects studied by means of disciplined, logical variable systems offer the best protection against one-sided success-oriented personality theories. The invaluable assistance of formal classification and notational structures in systematizing the data of human nature is one of the basic maxims of this book. The following chapter is devoted to this topic. The following example will serve to illustrate its usefulness in the context of the present discussion of social versus personal adjustment.

Illustration of the Impact of Cultural Values on Conceptions of Moral Character

In the process of developing a systematic list of interpersonal variables it is obvious that hostile and affectionate behaviors are among the commonly employed means of dealing with others. When we apply the principles of the normality-abnormality continuum, it follows logically that we must have linguistic terms for describing intermediate points along the continuum between these two interpersonal motives. This is to say, we must measure the moderate-adaptive and the intense pathological extremes of each motive. Thus, in devising rating scales, diagnostic terms, test check lists and the like, it is formally required that we have signs or terms to reflect the adjustively hostile, the adjustively affectionate, the maladaptively hostile, and the maladaptively affectionate.

When the Kaiser Foundation psychology research project began to develop a system of interpersonal variables, a puzzling linguistic situation was uncovered. It became clear that the English language—whether that of the psychiatrist or that of the general public—has a marked imbalance in the number of terms which describe different interpersonal themes. There was no trouble in obtaining long columns of words describing the positive, socially adaptive expressions of friendliness, amiability, love, agreeability, etc. Nor was there difficulty in listing maladjustive, pathologically toned denotations of extreme hostility, hatred, opposition, rage, etc. It was, however, a tedious task to get three or four commonly used words for the concept of adjustive, socially approved hostility. Considerable dictionary, thesaurus, and literary research uncovered a few such words—*frank*, *blunt*, *critical*—but it appears that the English language, and the implicit folk conceptions of human nature that underly it, pay little attention to the theme of appropriate expression of disaffiliative interpersonal behavior.

Interpersonal check lists were given to large samples of diverse subjects in order to obtain a balanced variable system and to determine the expected frequency of social motivations attributed to self. The logic of the personality system and statistical simplicity demanded a balance

between hostile and friendly terms, but the one-sidedness of the interpersonal terminology and conceptualization of Anglo-American culture made it necessary to employ such clumsy terms as *righteous anger, not afraid to be critical,* and the like, in order to express the theme of adaptive, appropriate hostility.

When we seek to find terms which express extreme, rigid maladjustive affectionate behavior, the problem becomes insoluble. There are no such simple words in the language. According to our linguistic forefathers, the human being cannot be *too loving.* The notion that one can be neurotically or compulsively affiliative is literally unthought of.

In this instance, the logical principles of the normality-abnormality continuum of interpersonal behavior and the discipline of a formal notational system lead to some interesting semantic, anthropological speculations and a further illustration of the one-sided *clinical error.*

What Is Adjustment?

In pointing out the limitations of classical psychiatry, and in advocating expanded symmetrical, logical principles for dealing with the normality-abnormality continuum, we have left untouched two vital questions: What is normality? What is neurosis? These are crucial issues because the theoretical position assumed on these questions is inextricably bound to the resulting conceptions of personality organization, diagnosis, and therapeutic orientation.

Horney presents changing and developing definitions of neurosis in her different publications. In general, she appears to see normality as flexibility, optimal productivity, as well as a relative emancipation from anxiety and the conflicts which accompany it. Fromm stresses productiveness, responsibility, mature affection, understanding, a rational handling of the authority relationship, and "freedom" from irrational dependence. Sullivan defines mental health as accurate, mutually rewarding interpersonal relationships. All of these authors are aware of the effect of the culture on our conception of normality. They point out that deviation from the norm must be viewed in the context of the social background. When Sullivan ties his most adequate mode of experience—the syntaxic—to consensual validation he recognizes cultural relativity, and holds that a "great deal of most people's syntaxic experience is bound by the prescriptions and limitations of the culture . . ."

When we survey these criteria of normality, two thoughts may occur. First, they are all partially valid, in the sense that they refer to aspects of adjustive functioning. Second, none of them is complete, systematic, or too well organized. Productivity, syntaxic function,

and achievement of one's potential are broad concepts, admirable foundations for a philosophy of human nature, but much too vague and general to be used as research and clinical variables.

From the standpoint of operational measurement, most definitions of normality are either too specific, and thus fragmentary, or too broad, and thus imprecise. This is because normality cannot be systematically defined until a comprehensive system exists for organizing the multiplex data of human nature. Personality processes operate at many levels and in many forms. The nature of the definition of neurosis is always chained to the nature of the system of variables by which the theorist classifies human behavior.

We shall obtain rigorous, logical, complex heuristic definitions of adjustment-maladjustment when we are given systematic multilevel definitions of human personality. Until then the conception of neurosis will reflect the level of personality to which the theorist is limited.

At this point in the discussion it is appropriate to introduce the theory of normality basic to the personality system presented in this book. To venture its definition at this early stage of the exposition is a hazardous proposition. Since a detailed description of personality organization has not been presented, a detailed definition of normality is premature. We shall be forced to employ undefined words, refer to undefined levels and their undescribed relationships. Fluent expression of nonoperationally defined terms is the easiest trap that awaits the personality theorist. We shall, with these reservations, present a verbal description of normality, at the same time referring the reader ahead to the systematic and operationally defined categories which are to follow in Chapter 12.

Adjustment in terms of the over-all personality organization consists in flexible, balanced, appropriate, accurate interpersonal behavior. In terms of the subdivisions of personality—the levels of public interaction, perception, and private symbolism—it consists of appropriate, accurate, and balanced interpersonal behavior respectively. When we re-examine this definition we shall see that each term has a rigorous quantitative meaning—referring to specific, operationally defined processes. In the broad scope, we call normality an equilibrium of all the levels of personality such that the necessary mild character distortions at some levels are moderately counterbalanced at other levels. A different subdefinition exists for each different level of personality. At the level of perception of self or others, accuracy or syntaxic agreement with consensual perception is a partial index of adjustment. At the level of overt interaction, the proportion of flexible interactions appropriate to the interpersonal stimulus becomes the index of adjust-

ment. At the level of indirect, fantasy expression, the breadth of symbolic themes and their balance and relationship to the other levels provides the ratio of adjustment.[1]

The verbal definition of adjustment presented above rests upon one basic (philosophic) assumption: survival anxiety as the motivating force of interpersonal behavior. This premise shapes the resulting theory of normality. It also focuses on certain types of variables (interpersonal), and requires certain formal multilevel systems for relating these variables. The conception of adjustment-maladjustment presented in this section, therefore, does not stand as an isolated verbal entity. This will become clearer as we examine, in later chapters, the specific and, in the following chapter, the general principles of the system on which it is based.

[1] In Chapter 12 operational methods for classifying and diagnosing behavior will be presented. This conception of adjustment is based on the notions of moderation, balance, and flexibility. In developing objective criteria for measuring these qualities we have found ourselves borrowing from certain historical antecedents and rejecting others. Moderation and the avoidance of extremes is, of course, the definition of adjustment sponsored by Aristotle. Flexibility and the avoidance of narrow, rigid forms of adjustment is the Renaissance ideal. The Christian conception of values views normality as a victor over man's intrinsic evil nature. This notion is reflected in the psychiatric theories of adjustment developed in the nineteenth century. It is a curious irony that empirical approaches to the definition of normality find their intellectual heritage in the Greek and Renaissance philosophies which are more distant in many other respects from the ethos of twentieth-century culture.

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Systematizing the Complexity of Personality

That segment of personality which we have selected to systematize centers on adjustive and maladjustive interpersonal behavior. Even when we narrow our field to the social dimension of personality, the systematic task remaining is terribly complicated. The diversity of interpersonal behavior covers a wide range. It includes all the things a subject does to others at all levels of personality—overtly, symbolically, and in private perceptions. When we add the parallel behaviors of others who do things to the subject we obtain a network of events that probably equals in complexity the data of the physical sciences. When we consider further the effects of culture, sex difference, and the peculiarly self-deceptive nature of emotional data, the enormity of the scientific task becomes clear.

In undertaking this complex mission, personality psychology can, fortunately, count on some conceptual assistance—new developments in the philosophy of science. In recent years considerable progress has been made by a group of logicians and positivist philosophers which is directly applicable to the field of personality. The study of human nature can find guide posts in the general principles which guide the physical sciences.

The Basic Conceptual Unit of Personality

We shall begin by considering a preliminary question. When we study the interpersonal behavior of an individual, what is the basic datum on which we make our judgments? The first answer to this question might be that we employ a variety of behavioral cues: projective personality tests, tales of woe from the interview, the angry tones of voice, dream texts, and the like. These are, it is true, the events, but

they are not the basic data for the study of personality. How can we measure these written, oral, and physical expressions in such a way as to provide comparative conceptual material? It is possible, but rarely feasible, to capture these events by sound and movie equipment. Even then we must decide what to do with these unwieldy materials when we get them.

For many years researchers have been working within one or another of these areas of raw personality data, painfully building up complex devices for categorizing the different surface types of expression. Hundreds of systems for dealing with personality tests have been published. We have learned, to our horror, that it is possible to devise measurement scales for each facet of personality expression. Thus, it is possible to have an elaborate continuum for rating each type of test, another for measuring the amount of sadness or depression expressed by the subject, another for classifying the nuances of tone of voice. None of these scales need any relationship to each other, and they leave unsolved the great paradox that personality must be considered as somewhat unified yet is expressed in a variety of ways.

Actually, a distressing amount of creative energy has gone into molecular, stimulus-bound research of this sort. One method of classifying the responses to one test, the Rorschach ink blots, involves over sixty elaborate and tricky rating procedures. These variables have direct reference only to the ink blots themselves, and by circuitous and generally unvalidated intuition refer to a few aspects of general behavior. This is a single example of the unfortunate and common practice of chasing one aspect of raw personality data down a tortuous side alley.

We have several score of personality tests, each of which employs tedious methods for summarizing an extremely artificial and narrow range of expressive behavior. Most of these tests force the development of miniature personality theories which work for the tiny segment of behavior that they tap. A test which uses sand and water as part of the stimulus items thus employs a theory which gives sand and water a prominent role in personality development.

The solution we have employed to deal with this unsatisfactory situation is to define as the basic data of personality, not the expressive events, but the communications by the subject or by others about his interpersonal activity. The basic units of personality come from the protocol language by which the subject's interpersonal behavior is described.

When the subject smiles we attend to it, but the smile is not the datum which directly concerns us. Someone who is present in the situation, or observes it in cinematic form, has to make a protocol

statement about this movement of facial muscles before it becomes a datum of personality. We study not the actual behavior, but the language about it (including the subject's language about it).

This may sound, at first impression, like a restricting definition. But when we remember that we can obtain many descriptions of the same momentary event, it actually provides a systematic way of multiplying our knowledge. The smile, for example, might elicit many data sentences. The subject himself might describe his motive purpose at the moment as friendliness. The consensual report of many judges might agree in attributing friendly purpose to the smile. A suspicious relative, however, might judge it as smug or patronizing. A dependent relative might attribute tender sympathy. Thus, this facial gesture produces many protocol statements which provide interpersonal information about the subject's description of self and his social stimulus value to others.

The basic data of personality studied by the interpersonal system are the verbal protocol statements about interpersonal behavior, i.e., the language in which the subject or others describe his interpersonal interactions, perceptions, and symbols. The diverse molecular responses—tears, bodily movements, test reactions—are the raw materials. From them we obtain the building blocks for the scientific study of personality. These are units of classification—terms such as *depressed, angry, confident.*

The Structure of Scientific Language

In the methodological aspects of the science, we use a wide variety of *empirical* techniques to obtain the raw data of personality. We utilize these direct observations by converting them into systematic protocol language. Scientific study of personality consists in a study of the systematic language by which we describe the many facets of behavior. These conceptual operations refer to the *formal* aspects of the science.

This important division of scientific procedures into empirical and formal propositions has developed out of the scientific philosophy of the twentieth century. Bertrand Russell and the Logical Positivists (Wittgenstein, Carnap, etc.) have helped to make the distinction between the synthetic operational language, which refers to measurable events in the physical-social world, and the formal analytic procedures by which the language of science is organized.

These two distinct types of scientific communications were redefined and a third pragmatic function added by C. W. Morris. This American philosopher claimed that all scientific activity can be studied as forms of the language of science. The general science which studies

the entire field of scientific communication he calls *semiotic*. He defines three different functions of scientific behavior: (1) *Semantics* studies the relation of signs to objects and thus covers the empirical, experimental, and methodological aspects of science. (2) *Syntactics* is concerned with the relation of signs to signs, and involves the formal procedures of logic, syntax, and mathematics. (3) *Pragmatics* deals with the relation of signs to the users of signs. This branch of semiotic studies the functional and applied meaning of communicative behavior. Let us examine Morris' three functions in more detail.

(1) Every science has unique methods and variables for dealing with its specific data. These variables and their relationships are described in terms of language. Thus, despite the great variations in what scientists do with their various data, the net result always involves communication or sign behavior.

Certain general rules hold for all empirical investigations. Among these we include the need for unambiguous operational definitions of terms, and the need for public and repeatable measurements, procedures, and the like. Morris calls these *semantic rules* since they govern the relationship of signs to the empirical events. All sciences differ, but all must conform to the same standards of objectivity.

(2) These empirical propositions which are related to observable and testable facts are crucially different from the formal propositional structures of a science. The latter comprise systems which regulate the relationship of signs or language units. They have no empirical reference. Such formal devices are indispensable because they determine how the researcher organizes his factual language. Mathematics and the logical deductive systems employed by modern science do not depend upon empirical proof. They are, in this sense, complex sets of terms which are inflexibly related to each other according to preestablished, assumed rules. The arithmetical statement "two times five equals ten," for example, is a predetermined relationship based on our original definition of what each of the terms means. This sentence is therefore empty of factual meaning. The psychoanalytic statement "the ego wards off instinctual impulses," is similarly formal, depending on the assumed relationship of ego and instinct. It has no empirical meaning.

(3) The pragmatic aspects of the language of personality delimit a broad and ramified field. They refer to the sociology of our psychological knowledge, its politics, its practical application in diagnosis and therapy. We have found it necessary to narrow the scope of the pragmatics of our system to the predictive function in the psychiatric clinic. We have selected the interpersonal framework because it appears to be the most functional in terms of survival of the individual

and a critical prediction of clinical events. In due course we shall attempt to show that every variable and every diagnostic category presented in this book has been chosen to predict directly the crucial aspects of the subject's future behavior—particularly with the future therapist. Thus we equate the pragmatics of personality psychology with prediction. From the standpoint of psychiatric operations—the orientation of this book—nothing is so important as to have probability knowledge of the patient's future pattern of interpersonal behavior. This interpretation of the pragmatics of personality is, of course, the narrow sector of the broad field outlined by Morris that is most pertinent to a clinical psychology.

With this threefold classification in mind, let us return to the distinction between empirical and formal propositions. Since empirical statements are related to and are limited to observable events, and since formal statements are not, it is of critical importance to distinguish between the two types of propositions. Failure to do so leads to dangerous fallacies. These generally involve tautological formal statements which appear to be empirical assertions. The psychoanalytic phrase just quoted, for example, refers only to Freud's logical structure of personality. It refers to the relationship between the language forms "ego" and "id" employed by Freud. The psychoanalytic linguistic system, which is the most ambitious yet developed in the field of personality, has restricted empirical reference. Those who employ Freud's verbal conventions often imply that they are making factual statements rather than logical tautologies. Crippling confusions and meaningless communications will inevitably result if empirical and formal statements and pragmatic operations are not kept clearly distinct.

If they *are* kept distinct several benefits accrue. The most important of these is the general ordering of scientific activity. From the chaotic complexity of personality data emerge three broad and distinct sets of operations—the empirical-methodological, the formal-logical, and the practical applications. Personality study currently faces these three challenging tasks: to measure objectively and meaningfully, to relate the obtained variables systematically and logically, and to apply the resulting knowledge with known predictive accuracy. We shall accomplish these objectives most efficiently by working within the principles of contemporary unified science. The rules for empirical methods (reviewed in Chapter 4) will guide our approaches to the raw datum, and its conversion into reliable language units. The formal principles will assist us in organizing our linguistic units. The goal of pragmatic applicability will encourage us to relate our systematic knowledge to external events and to functional issues. Seen

in this light, personality psychology becomes part of a unified general science.

The purpose and outline of this book can now be restated in terms of these three categories. The remainder of this chapter presents some basic principles, some of which deal with a Logic of Personality. The two subsequent chapters survey the empirical and functional aspects of the field of personality. Chapter 6 and the two subsequent sections (Part II and Part III) return to the same issues, presenting objective methods for measuring interpersonal variables and formal notational systems for relating them. In parts IV and V the pragmatic themes assume priority as we apply the conceptual system to problems of interpersonal diagnosis in and out of the psychiatric clinic.

The Selection of Personality Variables

We began by noting the complexity of personality. From the philosophy of science we obtained three categories of scientific discourse which help bring preliminary order to this diversity. This chapter goes on to present five working principles, which further assist in clarifying and systematizing the chaotic, fluid intricacy of human behavior.

The first issue concerns the variables, elements, or conceptual units to be employed in dealing with the enormously diverse range of protocol sentences which describe interpersonal behavior. Every personality theorist has faced the formal questions of how many elements or variables of personality are to be employed and how they are related. The first impression one might receive from many previous theorists is that personality structure is very uncomplicated. Scores of dichotomous variables have been offered as the basic dimension of human behavior—*schizothymic* versus *cyclothymic*, *introverted* versus *extroverted*, etc. As many three-way classifications have been popularized—*lean*, *fat*, *muscular*; *intropunitive*, *extropunitive*, *impunitive*; and the like. Most of these narrow conceptual solutions have quickly collapsed when asked to carry the heavy load of human variety. A *broad collection of variables* is a necessary answer to the question of "how many?"

Another, more elaborate but ineffective, solution to the problem of basic elements is to employ one extremely broad, vague variable such as *libidinal force* or *drive-towards-growth*. Motive concepts of this sort allow plenty of room for diversity but give no *specific* assistance to the empirical worker.

A broad set of simple and specific elements (that we have here held to be necessary) leads to another formal requirement. Several such

systems of variables have been developed by personality theorists. Many of the variables in these systems have tended to overlap each other, to overweight certain interpersonal behaviors, and to miss others. They have not been related to each other in a systematic order (i.e., on a continuum or scale). Henry Murray published (1), in 1938, an extensive list of human "needs" which has merited the considerable usage it has received. In a later publication, Murray has criticized his own eclectic collection of motive variables by proposing that social scientists "devote themselves more resolutely than they have so far, to the building of a comprehensive system of concepts which are defined not only operationally but in relation to each other." (2, p. 200) This demanding proposal, which we herewith include in our list of working principles, means that all variables should be related to each other along some kind of continuum. It means that each element should be located in fixed relationship to all others.

Collecting the strands we have been weaving so far in this book—interpersonal orientation, adjustment-maladjustment continuum, simplicity, specificity, systematic relatedness—we are ready to state another working principle which guides our approach to human personality.

THIRD WORKING PRINCIPLE: *Measurement of interpersonal behavior requires a broad collection of simple, specific variables which are systematically related to each other, and which are applicable to the study of adjustive or maladjustive responses.*

The Logic of Interaction

Another formal issue must now be met. Interpersonal behavior has been defined as the basic area of personality. It is in the essence of interpersonal phenomena that they never exist in isolation, but always in interaction with real or imagined others. We must conceive the interpersonal activity of the subject as he sees it, expresses it, and symbolizes it. We must, in addition, include his perceptions and symbolic views of others, as well as the responses which he pulls or obtains from others. An interaction psychology which deals with the issues of what-people-do-to-each-other runs headlong into another nest of classic philosophic entanglements—the subject-object dichotomy. Here we need another principle to clarify important issues.

FOURTH WORKING PRINCIPLE: *The interpersonal theory of personality logically requires that, for each variable or variable system by which we measure the subject's behavior (at all levels of personality), we must include an equivalent set for measuring the behavior of each specified "other" with whom the subject interacts.*

In interpersonal psychology the simplest proposition is a two-way proposition. The subject is always in observed, perceived, or imagined interaction with crucial "others." These "others" may or may not be real persons. Considerations of methodological economy always limit the number and extent of the interactions that we can study. Therefore, some "others" never get measured or placed on the summary charts.

The Multilevel Nature of Personality

We are engaged in this chapter in stating some working principles on which we shall base an adequate codification system for personality. The task of organizing personality data into logical categories reaches its climax when we face the problem of levels.

Recognition of the multidimensional aspect of human nature is a landmark in the development of personality theory. Freud's demonstration of the importance of unconscious motivation was an epochal intellectual achievement. The single-minded view of man as a rational being was supplanted by a binocular or multiocular vision of human character. It has revolutionized our concepts of personality. It has demonstrated that human behavior is not a unified single process; it is not just what it appears on the surface, nor what it is consciously assumed by the actor to be. It is rather a shifting, conflicted, multifaceted complex of motives, overt and covert.

The essence of modern personality psychology is its multidimensional character.

Commonsense notions about human nature tend to be unilevel. People tend to think that what they consciously believe and say about themselves is the entirety of their personality. They are often quite unaware of intense and pressing emotions which dominate and direct their behavior.

Experimental and academic psychology were until recently completely unilevel. The notion that what a subject reports is based on assumptions and motives which are not publicly stated came as a great surprise to the Behaviorists.

Most of the current research in the field of personality is still distressingly unilevel in its conception and research design. The standard instruments of personality research, the rating scale, the check lists and the Q-sort, can be rendered quite ambiguous by the introduction of multilevel logic. A typical research technique is to present a psychological judge with a test protocol—let us say an MMPI profile or a Rorschach record—and to ask him to rate the patient on a list of variables, or to sort a list of descriptive phrases about the patient. Multilevel logic requires that this task be rejected as meaningless. The

questions are immediately raised: Should I rate how I predict he will behave, or how he will consciously see himself to be, or what I predict his underlying motives are? The simple, old-fashioned procedure of rating the subject thus breaks down into three or four rating approaches, each of which may differ dramatically from the others at different levels.

Many generalizations about results in personality research are similarly crippled by a unilevel approach. This is particularly true in the case of psychiatric and psychosomatic studies. Statements to the effect that obese patients are dependent, neurodermatitis patients are guilty and ulcer patients are passive, are quite limited in meaning. They seem to disregard the essential and basic concept of modern personality theory—that the human being is a complex, multilevel pattern of conflicting motives and behaviors. The importance of a multilevel approach to personality can now be formalized.

FIFTH WORKING PRINCIPLE: *Any statement about personality must indicate the level of personality to which it refers.*

This is the key concept upon which this book is based. It will be noted in the clinical and descriptive sections of this book that no reference is made to behavior without the accompanying designation of the level from which it comes. Thus we say that ulcer patients are responsible and managerial—at the level of overt public behavior; that hypertensive patients are sweet and affiliative—in their conscious self-description; that dermatosis patients are masochistic—at the level of imaginative fantasy; etc.

The prudish (and often painful) circumlocution which this principle requires leads to a less graceful prose. It often puzzles and irritates the listener, who hopes to hear more definite statements about patients. In this connection we recall the staff meeting in which a psychosomatic research was being reported. An interested internist pressed for straightforward answers to his questions. "Are these patients passive and dependent?" The reply had to be cumbersome: "They are not at all passive at the two overt levels; they are significantly passive and dependent at the level of preconscious fantasy."

Diagnostic language in the same fashion becomes multiplied in complexity when a multilevel approach is employed. We no longer find it possible to rattle off a single diagnostic label. To the question, "Is this patient schizoid?" a diagnostician using the interpersonal system of personality would respond in three-layer terminology. A typical answer might be: "At the level of symptomatic behavior the patient is phobic; at the level of conscious self-description, hysteric; at the level of the preconscious, intensely schizoid."

We have discovered that it takes considerable patience and effort for psychologists to train themselves to think in multilevel terms. The behavioristic background of academic psychology apparently makes unilevel conceptions more congenial. Psychoanalysts, on the other hand, work comfortably and naturally in a multilevel idiom, although they are somewhat uneasy when their freedom to swoop from level to level is threatened by the limitations of operational definitions.

The Logic of Levels

The concept of multilevel behavior has immeasurably deepened our understanding of human nature. In addition to revising most of our psychological notions, it has broadened our interpretations of artistic, literary, and historical activity. Along with these intellectual boons, however, came a host of new problems and confusions. Much fallacious thinking has based itself on the conscious-unconscious dichotomy. Formal systems for clarifying the illogical language of dynamic psychiatry seem to be needed. The next few decades will undoubtedly witness the introduction of many new systems of personality. Although the content of the theories may vary, it is hard to conceive of a personality theory (in this post-Freudian era) which does not deal with the problem of levels. It seems inevitable that systematic and logical rules must be developed for dealing with the multidimensional aspects of personality data. The following principles seem to be so axiomatic as to hold for all such personality theories.

SIXTH WORKING PRINCIPLE: *The levels of personality employed in any theoretical system must be specifically listed and defined. Once the logical system of levels and relationships among levels is defined, it cannot be changed without revising all previous references to levels.*

Illogical procedures will nullify the most brilliant concepts. Good logic, on the contrary, is one of the most powerful instruments we can use in forging a theory. The postulates just suggested for dealing with the problems of levels inevitably force an increase in theoretical precision and scope. Listing and defining levels leads to improvements in empirical operations by clarifying the different sources of data contributing to each level of personality. This procedure has led us, for example, to the discovery that different probability laws hold for the different levels. Defining the formal relationships among the levels immediately reveals overlaps, tautologies, and previously undefined relationships of considerable theoretical promise. The conceptual issues of conflict, discrepancy, and motivating forces become sharpened. New conceptual entities become apparent. New research

hypotheses develop. Indicating and consistently maintaining the levels of the data allow language usage to become more public and precise. A final and perhaps most important advantage of notational systems is that good logic breeds better logic. Any formal system should reveal its own limitations and restricting assumptions. This, in turn, helps to father new and improved generations of successors.

Multilevel Relatedness of Variables

This chapter has been concerned with organizing the complexity of behavior into orderly classifications. Four working principles have been presented. They refer to variable systems and the levels of behavior at which the systems are employed. Before this discussion is concluded, one final principle must be discussed.

SEVENTH WORKING PRINCIPLE: *The same variable system should be employed to measure interpersonal behavior at all levels of personality.*

This means that we shall use the same classificatory elements regardless of the level of the data. Most dynamic or multilevel systems of personality do not follow this suggestion. They employ one classificatory language for covert, underlying themes and another language for describing overt behavior.

There is a significant advantage in using the same variable system at all levels. It is possible to make direct comparisons between levels. It is possible to measure discrepancies, conflicts, or concordances among levels. These measurable indices of discrepancy, which we call indices of variability (some of which are like the traditional defense mechanisms), are useful in several ways. They fill out our clinical picture of the personality by providing quantitative indices of the amount and kind of interlevel conflict. They are valuable indications of the interlevel organization of personality. They make possible objective research into such concepts as identification, repression, and idealization.

Summary

The themes of this chapter are the complexity of personality and the requirements for dealing with it systematically. The general strategy to be employed should now be clear. First, we set up a broad variable system of interrelated variables. We use this to classify the interpersonal behavior of the subject and his world at several levels of personality.

The essence of this approach is that we obtain thousands of single, specific, reliable molecular measurements. This makes for an objective system. We get at the complexity of personality by setting up the

system of levels, then studying and comparing a pattern of hundreds of scores at the different levels.

We do not employ clinical rating or intuitive judgments; although these are often broad, penetrating, and give a well-rounded picture of the personality, they are notoriously unreliable and unduplicable. For this reason we do not use professional psychological ratings at any point in the organizing of data. The procedure of automatically sorting thousands of reliable unilevel ratings into a standardized multilevel system allows us to pay some respect to the complexity of personality without sacrifice of objectivity.

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4

Empirical Principles in Personality Research

In the preceding chapter it was asserted that logical procedures are required to order the data of any science. Prior to these formal operations, however, comes the issue of collecting the data. This includes observing the raw events and performing some kind of discrimination or measurement. Empirical rules are required for this aspect of scientific activity. The interpersonal system of personality has attempted to follow three commonly accepted rules of scientific activity which can be formalized in a general working principle.

EIGHTH WORKING PRINCIPLE: *Measurements of interpersonal behavior must be public and verifiable operations; the variables must be capable of operational definition. Our conclusions about human nature cannot be presented as absolute facts but as probability statements.*

Personality Variables Must Be Public and Verifiable

The first criterion of scientific activity insists that it must be public and verifiable. Any statement we make about the world of events must be subject to independent check. Its validity eventually rests on its confirmation by other scientists. While this *social criterion of knowledge* has engendered some qualifying controversy in the philosophy of the physical sciences, its employment in personality psychology at the present time is particularly necessary.

Psychology, more than any other modern discipline, has been hampered by the issue of "private" observation. Many respectable scholars have flatly rejected the public testability principle and have endorsed a discipline of introspection, intuition, and anarchic individuality. Many brilliant clinicians still stick by the principle that the human being is a unique and rather sacred pattern of individuality

and that any attempt to find lawful generality is futile, insulting, and vaguely inhuman.

The patient-oriented approach of the practitioner is highly creditable, and needs no defense. To the clinician, the only principle involved is the welfare of the patient. There is, however, another important aspect to this question. Our technical competence to serve a patient is limited to our *generalized, probabilistic lawful knowledge* of human nature. Good will and patient-oriented solicitousness are virtues, but they are not professional instruments. Many skillful clinicians overlook the fact that they carry around inside of themselves a complex set of unverbalized and often unconscious generalizations about human behavior, which they apply to cases. Their patients get the benefit of an unsystematized lawful wisdom. These principles are often uncommunicable, unorganized, unteachable, untestable. They produce nothing toward the broad social goal of a science of human nature.

The integrity and productivity of good clinicians, however, more than justifies their unilateral approach at this primitive stage in the field. They violate no scientific canons because they do not pose as scientists.

As soon as a clinician begins to lecture or write about principles of personality, however, he puts himself into the area of discourse that must be bound by the laws of scientific evidence. The first of these necessary conventions is that the events, the data, be open for independent verification by other scientists.

There is a necessary objection which holds that psychotherapy cannot be studied objectively because the crucial events—the interpretation, the instant resistance of the patient, etc.—cannot be repeated. This comment is quite beside the point. The data of personality are communications about human behavior—descriptions of the subject by himself and by others. The reliability and verifiability of these can be established by means of the most basic recording or data-preserving devices. The attempt to derive generalizations about human-personality-in-therapy probably will involve the use of objective electric recordings of the therapy process.

With simple devices of this sort, it is possible to have any number of independent experts repeat and verify the most complex variable measurements. Without them psychotherapy becomes a wise but uncommunicable art. When it becomes clear that the unit of personality or interaction is the discriminatory element or variable, it also becomes quite feasible to obtain any number of equivalent repetitions of the variable by increasing the sample of subjects or of future observations. While it is true that any raw personality expression is unique

and unrepeatable, the basic variable units by means of which we classify behavior are, by definition, general, recurrent, and verifiable.

Operational Definitions of Terms

A second and related aspect of scientific method which holds for personality psychology is that of operationism. This principle requires that terms be defined by the empirical operations which produce them. In the words of Bridgman, "We mean by any concept nothing more than a set of operations." The relationship between the terms we use and the empirical operations by which we discriminate them must be direct and openly expressed.

In philosophy, the healthy impact of the operational definition has been to sweep away many metaphysical pseudoempirical concepts for which no external reference existed. In psychology many terms which have had dubious speculative histories have taken on new objective significance as researchers have linked their meaning to the empirical procedures by which they were measured. In personality and psychoanalytic theory—fields where undefined or privately defined concepts flourish like jungle growth—much less operational redefinition has occurred.

There can be many operational definitions of the same concept. Each scientist may find it necessary to use different sets of data to define, for example, unconsciousness. One may use dreams. Another may employ fantasy stories, and another, slips of the tongue. As long as each worker clearly states the classificatory operations to which he relates his term there is no objection to the individual differences in approach. The rest of his colleagues are free to accept or reject his theories, but they cannot deny the empirical adequacy of his approach.

Now, this flexibility of the definition process is not cause for alarm, nor is it a sign of any peculiar looseness of the personality field. The validity and meaning of any scientific fact is never exact or final. It always depends, among other things, on the type and level of the measurement methods involved. Only metaphysics can claim the luxury of finality and complete unambiguity. As the philosophers of operationism have pointed out, there are many ways to measure distance—a yardstick, a mileage indicator, a transit reading. Each of these can be valid in its own area of discourse. Many of them can be combined into the same classification. Many cannot, at this point. Similarly our illustrative operational definitions of unconsciousness are (to the extent that they are independently confirmed) all valid. Many of them may be combined. It might, perhaps, be determined that dreams and fantasy stories tap the same level of unconsciousness, and allow a broader combined definition of unconsciousness. Slips of the

tongue, possibly, might not be so related, and therefore would define another level of unconsciousness with its own particular lawful predictiveness.

The concepts of operationism have added powerful synthetic tools to the scientific method. Operational definitions have a remarkable capacity for ridding the language of any discipline of broad, impressive, but empty, terms which have no empirical meaning. Applied to the terminology of psychiatry, operationism calls for the elimination or systematic redefinition of almost every current concept. Operationism's "radical implications for psychiatric theory and practice" have been programmatically cited by Mullahy. He believes that "there is no chance that psychiatry will ever be a truly scientific field of inquiry until, as a first step towards scientific progress, it adopts a language sufficiently precise that its practitioners as well as workers in allied and related fields can in various ways check and verify the correctness of statements made by one another." (1, p. 58)

The Probability Nature of Predictive Accuracy

There is a third empirical principle which has importance for personality psychology. This has to do with the ultimate validity of empirical knowledge. It holds that there is no absolute or final truth, that scientific laws are never completely accurate, and that the only knowledge we can have of the empirical world is probable knowledge. The essence of scientific explanation is the known relative accuracy of predictions.

We tread here on the most ancient and hallowed ground of Western philosophy—epistemological questions about the validity of knowledge. Within the last century statistical mathematics, post-Newtonian physics, and the operational logicians have produced converging solutions that are closely related to the needs and complexities of a functionalistic personality psychology.

The most accurate statement any scientist can make about the world of events is an indication of the probability of occurrence. The chances are, let us say, three to five that a certain patient will develop passive resistance to a male therapist. But the chances are also two to five that he will not. Or we might determine that two thirds of the patients with duodenal ulcers will deny feelings of passivity and weakness. Of the one third who do not, 80 per cent manifest another specific interpersonal behavior—most likely schizoid withdrawal. When we have accumulated thousands of probability figures of this sort, based on publicly managed variable systems and organized into multilevel conceptual systems, a scientific structure of personality facts will have been established. Predictive procedures of

limited but known accuracy will be at hand. Moreover, the complexity and variety of human nature need never be threatened by the necessary oversimplifications of our predictive structures. There can be as many different systems as there are different dimensions of personality or of facets to the interreacting environment. The system described in this book is one such conceptual apparatus. It is designed to make factual predictions about the interpersonal dimension of behavior in the clinical situation. This is really a very narrow slice of the wide and varied expanse of human behavior. Other systems will continue to appear. New variables will be developed. Broader areas of human behavior will be encompassed and integrated. The essence of scientific activity is that new theories, new facts never push out the old. They add, they revise, they refine, they expand.

Thus we shall in later chapters present operational definitions of several psychiatric and personality variables and probability statements about their application. But no note of finality will be sounded. Future theorists will unquestionably present different and more effective definitions of the same concepts—based on different operations and boasting, perhaps, higher probability relationships to functional criteria. To the extent that these varying approaches are objective—communicable and operationally grounded—the new findings will not disprove nor quarrel with the old. No scientific fact can be disproved. It can be reinterpreted, qualified by new relationships, amplified to fit new material. Scientific findings do not compete, debate, or attack each other. They add, expand, and collaborate to develop new hypotheses. This characteristic of the scientific method is particularly important in the study of human nature and has been often neglected.

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5

Functional Theory of Personality

The preceding four chapters have presented a sequence of principles which serve as background to a science of human nature. This chapter discusses the functional purpose of scientific knowledge in general and psychological knowledge in particular. In so doing it calls upon and offers some synthesis of the principles already presented. There is more speculation and value orientation than in the preceding chapter.

The Aims of General Science

The ultimate objective of scientific activity is to explain and predict. To control, change, cure, and improve are worthy motives. These latter tasks fall, however, within the province of the applied professions—engineering, administration, medicine, psychiatry. The job of the scientist is to explain as accurately and as completely as possible the relationships among variables and to predict future events.

We explain any event by determining the probability relationships it has with other events. Increasing the temperature above a certain point is related to the boiling of water. Relationships of this sort in the macroscopic physical world have such regularity that extremely high predictability or exceptionless cause-effect sequences are generally observed. The fields of atomic and subatomic physics and of human behavior involve such a multiplicity of interacting events that deterministic causal laws are not possible and probability statistics define the order of relationship. "The more rejecting the parents are, the higher expectation that the child will manifest a defensive suspiciousness." Did the parents' rejection *cause* the child's distrust? It is much preferable to say that the two are correlated to a specific degree.

Probability laws allow us to make generalizations of known accuracy about the subject matter. Many established relationships among variables allow an increasingly higher order of generality. The breadth and sharpness of the explanatory process grow.

But why do scientists attempt to explain natural and psychological events? What is the function of the generalized knowledge so accumulated? These questions lead us to the other aim of scientific activity—prediction.

The purpose of scientific explanation is to predict functionally useful events of the future. This conception of the scientist's role (which is, by the way, an opinion rather than an axiom) is a humanistic one. It assigns his social function in response to social demands and sees him as a human being always stimulated by and limited to cultural pressures.

It is interesting to speculate that the human quest for knowledge has been strongly related to man's motivation to know the future. Knowledge of things to come has an enormous and obvious survival value. A major proportion of man's cognitive, philosophic activity is tied to his desire to anticipate correctly the future. Every religious interpretation has had to rest its dogma on a forecast about the nature of an afterlife. Much of its irrational and powerful appeal rests on this function. The interpersonal counterpart of these speculations might hold that ignorance is experienced as weakness, helplessness, and survivally dangerous. Knowledge is experienced as mastery and autonomy. It is survivally crucial in its function of forecasting the future.

The time-bound essence of human life requires that man anticipate the things to come with reasonable accuracy. Science as the broad branch of human activity entrusted with the development and classification of knowledge accepts the function of prediction.

An activity often erroneously assigned to scientific activity is the function of control. Ideally there should be no reason why the application of pertinent knowledge to human problems should not be accomplished by the scientists who derive it. In actuality, the interpersonal behavior of human beings—particularly along the power axis—is so corruptible that there is good reason for the division of labor. Objective, effective scientific activity apparently suffers in direct proportion to the intensity of the interpersonal network involved.

It is, thus, the task of the applied disciplines to use the predictive facts accruing from science. This distinction is not an invidious one. The years of technical training involved in the service professions—medicine, engineering—is often as great as or greater than that of the scientist. The responsibilities undertaken are invariably larger. So are the salaries.

Neither is this distinction absolute. Most researchers employed by nonacademic institutions—whether industries or clinics—are generally forced to play a double role. They follow their scientific noses and

are also led by them. This collaboration of the scientific with the applied is generally a fortunate one. Certainly for the problems of psychotherapy and personality change it is hard to see how much can be accomplished without complete clinical training as a minimum and considerable clinical practice as an optimum.

Functional Theory of Personality

To this point we have examined the functions of science in general. Turning to personality psychology we have seen the objective of this field to explain and predict interpersonal behavior.

Objective empirical methods provide innumerable probability relationships among specific variables. Formal and theoretical structures suggest how these are to be further related. This procedure poses new hypothetical questions. These are tested by additional empirical facts. This reciprocal progression of finding and theory establishes an increasing number of factual clusters which themselves become related to higher level theories.

As understanding grows, the predictive power of the science becomes more accurate and extensive. The functional importance of the field grows, usually encouraging new cycles of empirical activity.

The complexity of human nature is such that there are countless facets of behavioral data and an equal number of empirical problems. The conceptualization and terminology of the field clearly depend on which of these aspects of personality are studied. The psychologist who spends all of his time measuring and relating variables of *energy level* will generally develop terms and theories that have something to do with *energy*. Even when we define personality in terms of the interpersonal behaviors, a broad scope remains. Every individual has been in crucial interaction with others since the day of his birth, and his history of past relationships is rich. Concentrating on the present rather than the past, we see an enormously extensive network of interpersonal reactions. Relationships in the family situation, in the job situation, or in the social sphere all have some explanatory value. In attempting to predict, which facet of social behavior should be focused on? We might be able to predict the interpersonal consequences of a subject's marriage to this girl, of his election to that office in the Masonic Lodge, or of the selection of a certain program of psychotherapy in the clinic. The relevance of the prediction clearly refers to the problem being posed or the questions being asked. Prognostic knowledge is generally of value to the extent that it is relevant to the human problems at issue. To go further, it is most functional when the variables and terminologies of explanation are directly related to, or

even in terms of, the functionally important activities. For clinical psychiatry this means that the variable language should refer most directly to the interpersonal interactions that determine a successful or unsuccessful clinical relationship. This point brings us to the question of functional diagnosis and deserves further illustration.

Functional Diagnosis

Let us suppose that a psychotherapist comes to the predictive diagnostician posing this narrowly defined hypothetical problem. "In my office there is a male adult patient with asthma; what predictive statements can you make?" By studying the accumulated generalizations at hand the diagnostician might make any number of predictions. He might report, "The chances are better than two to one that your patient is married." This interpersonal prediction could be based on testable evidence, but it has little relevance to the situation at hand and little functional meaning. The diagnostician might report, "The chances are better than two to one that any asthmatic condition is related to psychogenic factors and is therefore psychosomatic." This is a descriptive, nosological statement. It has some relevance in that the psychiatrist can continue his clinical procedures with better than average chance that a psychological problem is related. It certainly does not throw much further specific light on the problem.

A third possible answer might be, "Over 60 per cent of these patients during childhood show marked ambivalence toward the maternal figure and intense oedipal conflict with the father." This historical explanation is clearly more pertinent to the understanding of the patient. It might lead to extrapolating conjectures from the past to the future, and might assist in clarifying this patient's relationship to others including the future therapist.

A fourth illustrative forecast might state that "Over 65 per cent of asthmatic patients tend to be compulsively orderly and punctual." This is a testable psychological statement relating to the present, but it is molecular and peripheral, and has limited practical meaning. It is not directly interpersonal. It refers to stylistic symptoms rather than crucial purposive direction.

None of these illustrative answers is adequately functional. They all can be true. They all might have some relationship to the personality organization of the patient, but their bearing on the situation is not central. The pressure of the human problem at stake is not effectively met by these statements. In the clinical situation, a generalized statement is most relevant to the extent that it predicts the future course of clinical progress. A diagnostic statement about a

psychiatric patient is most functional to the extent that it forecasts interpersonal behavior pertinent to the therapeutic handling of his problem.

The patient cannot change his childhood experience, although it is very true that he can learn from it. The historical prediction is, thus, valuable, but not crucial. Nor is the patient's situation very dependent on diagnosing him psychosomatic. The diagnostic label is made by and is important to the clinician, and not to the patient. Changing this descriptive term would have very little effect on the symptom or the underlying character structure. Neither does the symptomatic molecular prediction about compulsive orderliness have central importance. The punctuality and neatness are undoubtedly related to basic interpersonal motivations, but to focus on them diagnostically or therapeutically would not be a recommended course of action. These stylistic "how" variables of personality take on their vital meaning when they are traced back to the interpersonal purposes which they serve. To change just the peripheral, noninterpersonal trait is not the essence of therapeutic improvement.

The most functional answer to the clinician's question might go like this, "Over 75 per cent of male asthmatic patients who come to a psychiatric clinic manifest autonomous and stubborn competitiveness with males of superior or equal status. Conscious awareness of this intense fear of weakness is generally followed by overt signs of severe anxiety and increased competitive behavior. The chances are three to two that these patients will interrupt therapy in autonomous resistance." This prediction serves to illustrate the issues of relevant prediction and functional diagnosis.[1]

A statement of this sort is preferable for several reasons. It is interpersonal. It relates to the future; not just to one expected event, but to a sequence of interaction (which is related to a conflict between levels of personality). It relates the expected interpersonal pattern to an estimate of treatability. The diagnostic concepts are expressed directly in terms of predictive behavior which has bearing on the future treatment relationship. The future therapist is told specifically how the patient might be expected to react to the therapist and to the treatment process. His attention is directed to the interpersonal responses which have so much to do with the success or failure of the therapy plan.

This last is an interesting sidelight of functional terminology. The predictive terms that a diagnostic system employs not only reflect its theoretical focus. They also exercise a subtle but marked effect on the subsequent use made of the information. If a theoretical system (and

[1] See Appendix D for an illustration of a personality report employing the interpersonal system to make a practical prediction about a patient's behavior in the clinic.

the diagnostic terms it sponsors) emphasizes past events of the case history, it is likely that the following discussions will tend to emphasize these areas. If the predictions in the hypothetical case employ the language of compulsivity, punctuality, and the like, the facets of behavior may be unduly attended to in the interviews that follow. Suggestibility and selectivity of content cues are the constant errors of psychotherapy. The less experienced or the less flexible the therapist, the more influence accruing to this indoctrinating effect of diagnostic terms.

In clinical practice we assess the functional value of a personality or psychiatric variable in terms of the predictive value for facilitating the future clinical relationship. Terms which have high predictive value (even if indirect) tend to remain in popular use. Terms which have little predictive "cash value" tend to disappear. Every psychiatric term possesses a cluster of prognostic nuances which influence the intake and therapeutic diagnosis. Most of these predictive attributes are vague, unproven, often implicit, but they carry a staggering load of responsibility.

Schizophrenia, for example, brings to mind a host of prognostic associations, "not a good outpatient," "poor risk for brief therapy," "poor risk for psychoanalysis," "supportive or ego-strengthening methods favored," "long institutional treatment optimal," "generally slow prognosis," etc. These distillations of clinical wisdom are unsystematized, unverified probability statements about the future behavior of schizophrenic patients. The original diagnosis is presumably based on other classes of variable cues. That is, the patient is originally diagnosed schizophrenic because of delusions, withdrawal, marked projections on or misperceptions of reality, and the like. Some psychiatrists hold that the best diagnostic sign indicating poor prognosis is the elicitation of hallucinatory material.

This type of informal clinical folklore is a necessary and healthy development in an infant field. The criteria of prognostic value (however vague the variable relationships) indicate that the discipline is struggling toward a predictive status. As this process occurs the usage of certain terms with lesser prognostic power begins to diminish. They maintain only descriptive and administrative popularity. *Hebephrenic* is such a term. Outside of some crude differentiations from the folklore of the shock ward there is little *prognostic* specificity which distinguishes this term from, let us say, catatonic.

The most functionally important aspects of human behavior seem to be the interpersonal. To understand a human being is to have probability evidence about his relationships with others (perceived, actual, or symbolic), about the durable interpersonal techniques by which he

wards off anxiety, and about the reciprocal responses these techniques pull from others. To make meaningful predictions about a human being is to translate our explanatory data into statements as to the expected interpersonal behaviors in specific functional situations.

Explanatory concepts which deal with instincts, body apertures, symptomatic manifestations, and peripheral stylistic traits have indirect value to the extent that they can be related to interpersonal behaviors. It is not really of much use to a future therapist to predict that his patient will be punctual and not flick ashes on the rug.

It seems quite possible that within a few decades the slowly evolving laws of pragmatic usage will establish interpersonal concepts as a popular and useful diagnostic language. Two possibilities suggest themselves here—the first is that direct interpersonal terms will replace the disorganized nosology of present-day psychiatry; the second is that the current terms will be redefined in interpersonal terms. If the first alternative is accepted, terms such as psychopathic personality or schizoid personality would disappear in favor of specific systematic interpersonal labels. According to the second alternative, psychopathic personality would be redefined operationally in terms of the rebellious aggressive criteria, and schizoid personality would have as its basic diagnostic indices distrust and bitter withdrawal. This is another historical issue that time will settle.

The system described in this book employs the latter—more conservative—solution for developing a functional, operationally defined language of personality which will work for both adaptive adjustment and the psychiatric extremes.

Functional Concept of Personality

Two general postulates, which have been woven in as background for all of the discussions so far, hold that the functional core of human behavior is the interpersonal, and that personality concepts must be defined along adjustment continua which include both normal and abnormal reactions. When we approach the problem of a functional personality language with these two principles in mind, certain solutions seem to follow quite readily.

The first assumption clearly demands that the basic set of personality variables be not symptomatic, erotogenic, or stylistic, but interpersonal. The second assumption suggests that each of these variables must have an intensity dimension such that its rigid, maladaptive extreme be as readily classified as its moderate adaptive aspect. The measurement categories all along this scale are still interpersonal—as we recall from the hostility continuum described in Chapter 2, where *blunt*, *frank*, *appropriately critical* were terms referring to the adaptive

and *sadistic*, *aggressive* to the maladaptive end of the continuum. Now it is well known that the language of psychiatry deals almost exclusively with the pathological extreme of behavior. Thus we discover that maladaptive extremities of the continuum for each generic interpersonal motivation are most closely related to and overlap the psychiatric. In the illustration of the hostility continuum just mentioned, it will be noted that *sadistic* and *aggressive* have a much more psychiatric flavor than do *blunt*, *frank*, *appropriately critical*, and the like.

It seems to follow, then, that if we painstakingly study all the forms of interpersonal behavior in as many environmental situations as possible, we shall obtain, after grouping and sifting, a finite number of discernible basic interpersonal motivations all of which must (according to the normality assumption) be placed on adaptive-maladaptive continua. For each pathological interpersonal pattern we observe in the clinic there must be an adjustive aspect. And for each successful social maneuver we meet in the market place there must be a pathological extreme. The surprising linguistic imbalance which implies that an Anglo-Saxon cannot be too affectionate or adaptively disaffiliative has already been commented upon. The implications of this imbalance for systematic functional diagnosis will be developed in later chapters.

Since the neurotic interpersonal intensities tend to overlap some aspects of the noninterpersonal psychiatric categories, we have close to hand a solution for the problem of what to do with these latter less functional terms. The process of redefining them begins to take place automatically. Most of the popular diagnostic labels have vague, undefined, but fairly effective functional power. They have interpersonal correlates. To be skeptical, realistic, and reserved is generally an adaptive interpersonal pattern. To be inflexibly distrustful and withdrawn is invariably maladjustive. Many psychiatrists would call it schizoid. Thus we see the possibilities of redefining the classical language of administrative psychiatry in interpersonal terms. This preserves the usefulness of the older terminology while sharpening its denotive power. On the other hand, from the standpoint of the interpersonal system we have added a new set of partially interpersonal terms to our linguistic structure which is broadened thereby. The extreme points of the scales now have a new set of descriptive terms which are unique to the professional specialists of the clinic but which relate to the broader system of general interpersonal psychology. An interpersonal notational system holds the promise of bridging the ancient and logically intolerable gap between the science of personality and the practice of psychiatry.

There will probably be many such reciprocal rapprochements in the next phases in the study of human nature. The scientist or systematist will do well, we suggest, to keep his general concepts from being swallowed up by the more exciting linguistics of the clinic. It is most valuable to stress the relationship between general concepts of personality and the terminology of the practitioner. It is important, however, to maintain the basic nature of the generic interpersonal systems.

If this is done, the possibilities of relating the general sciences of interpersonal behavior with other applied and pure disciplines in addition to clinical psychiatry appear bright. There is, for example, good reason to feel that occupational adjustment is mainly determined by interpersonal factors. Whether the applied field is vocational counseling or industrial management, the terminology of job classification is very likely to have interpersonal correlates, with, perhaps, even more overlap than psychiatric labels. These vocational "diagnostic" terms are most likely to be located near the adaptive and moderate end of the normality-abnormality continua—*blunt, frank, realistic, amiable,* etc. A similar cross-fertilization and functional application seems quite feasible. Wherever an applied discipline requires psychological (not physiological) answers to the problems it faces, an interpersonal psychology will generally be best equipped to make the most basic explanations and the most functional predictions.

The Working Principle of Functional Applicability

The functional orientation which has just been described can be summarized in the form of a guiding statement.

NINTH WORKING PRINCIPLE: *The system of personality should be designed to measure behavior in the functional context (which in this book is the psychiatric clinic). Its language, variables, and diagnostic categories should relate directly to the behavior expressed or to the practical decisions to be made in this functional situation. The system should yield predictions about interpersonal behavior to be expected in the psychiatric clinic.*

6

General Survey of Interpersonal and Variability Systems

The preceding five chapters have presented a general, theoretical discussion of some of the basic requirements of an adequate science of personality.

By way of summary the nine working principles which have guided the Kaiser Foundation research in personality will now be reviewed before surveying the personality system.

Nine Working Principles for the Interpersonal Theory of Personality

(1) Personality is the multilevel pattern of interpersonal responses (overt, conscious or private) expressed by the individual. Interpersonal behavior is aimed at reducing anxiety. All the social, emotional, interpersonal activities of an individual can be understood as attempts to avoid anxiety or to establish and maintain self-esteem.

(2) The variables of a personality system should be designed to measure—on the same continuum—the normal or "adjustive" aspects of behavior as well as abnormal or pathological extremes.

(3) Measurement of interpersonal behavior requires a broad collection of simple, specific variables which are systematically related to each other and which are applicable to the study of adjustive or maladjustive responses.

(4) For each variable or variable system by which we measure the subject's behavior (at all levels of personality) we must include an equivalent set for measuring the behavior of specified "others" with whom the subject interacts.

(5) Any statement about personality must indicate the level of personality to which it refers.

(6) The levels of personality employed in any theoretical system must be specifically listed and defined. The formal relationships which exist among the levels must be outlined. Once the logical system of levels and

relationships among levels is defined it cannot be changed without revising all previous references to levels.

(7) The same variable system should be employed to measure interpersonal behavior at all levels of personality.

(8) Our measurements of interpersonal behavior must be public and verifiable operations; the variables must be capable of operational definition. Our conclusions about human nature cannot be presented as absolute facts but as probability statements.

(9) The system of personality should be designed to measure behavior in a functional context (e.g., the psychiatric clinic). Its language, variables, and diagnostic categories should relate directly to the behavior expressed or to the practical decisions to be made in this functional situation. The system, when used as a clinical instrument, should yield predictions about interpersonal behavior to be expected in the psychiatric clinic (e.g., in future psychotherapy).

In the next six chapters (which comprise the second section of the book) these postulates will be employed in an attempt to construct such a system. The nature of these requirements tends to determine and limit the resulting personality system. In this chapter the over-all organization of the personality system will be described in terms of (1) a schema for classifying interpersonal behavior and (2) a formal notational system for defining and relating the levels of personality. The subsequent chapters will focus respectively on five levels of personality and the way in which they are combined and used for interpersonal diagnosis.

Before presenting the outline of the personality system, let us illustrate by way of review the importance of formal theory for dealing with the levels of personality. Some remarks by the philosopher Reichenbach (on the value of symbolic logic) may be appropriate in this connection. He suggests that:

> The introduction of a symbolic notation is important to logical procedure because "it has about the same significance as a good mathematical notation." Suppose you are given the problem: "If Peter were 5 years younger, he would be twice as old as Paul was when he was 6 years younger, and if Peter were 9 years older, he would be thrice as old as Paul, if Paul were 4 years younger." Try to solve it in the head by adding and subtracting and considering all the "if's," and you will soon arrive at a sort of dizziness as though you were riding on a merry-go-round. Then take a pen and paper, call Peter's age x and Paul's age y, write down the resulting equations and solve them the way you learned it in high school—and you will know what a notational technique is good for. There are similar problems in logic. (10, p. 219)

There are also similar problems in dynamic psychology. Consider this not atypical case report from a psychoanalytic journal. The author describes a multilevel pattern of the patient's emotions as follows:

While expressing aggression toward a male cousin, she thought once again that she smelled gas. At first by allusion to others, then by way of dreams, there emerged the fantasy that the analyst was feminine; then she admitted never having thought of her father as a man, but as a woman.

She wished she could dominate the analyst and others as she felt dominated at home. This aggressive urge was accompanied by increased feelings of guilt. At a time when she had unconscious conflicts about not paying for cancelled hours, and also had arranged for more advanced art lessons which would increase her abilities and prestige, she stuck two fingers into an electric fan, and was unable to work.

Seductive fantasies toward the analyst, as well as homosexual dreams and fantasies, and dreams of being gassed and raped emerged in connection with memories of compulsive masturbation in her childhood, causing vaginal discharge which she had had impulses to eat. After confessing her "dirty thoughts" she had a dream.

> "She stood before a mirror admiring herself, dressed in a beautiful flowing white dress."

She said this dress made her look "effeminate" and then felt embarrassed at the use of the word. She felt that to be beautiful would serve two purposes: to make her sister and other girls feel inferior to her, and to control men. She had often thought mouth and vagina were equivalent.

After this dream she became cleaner, worked better, and began to earn her way both by art work and by working in a department store. Competitive strivings in regard to other patients, as well as her sister, came out more clearly in association to wishes to be dirty. (7, p. 79)

If the reader attempts to organize this series of conflicting events, to sort out the levels and the motives which belong to them, ambivalent, autistic, past, present, he may acquire a sort of vertigo similar to that mentioned by Reichenbach.

This analyst has combined at least four or five levels of behavior in this passage. He describes certain overt actions of the patient: "expressing aggression," "arranged for art lessons," "stuck two fingers in a fan," "worked better," "began to earn her own way." All of these actions are public—and could be consensually validated by listeners or observers.

The analyst also mentions certain wishes, urges, or impulses which the patient reported: "to dominate the analyst," "to eat," "competitive striving." These impulses, consciously recognized but not acted out, must be kept systematically distinct from the above-mentioned overt actions.

Another level at which this patient operates is that of dream or fantasy: "that the analyst was feminine," "her father as . . . a woman," "seductive fantasies" toward the analyst, as well as homosexual dreams and fantasies, and "dreams of being gassed and raped," etc. These autistic productions are clearly deeper or further from reality than the overt activities or the secret wishes previously summarized.

To these three levels we might also add the deeper unconscious conflicts and the conscious reports—both of which denote different orders of reality-contact and consciousness.

Free association protocols, case histories, and reports of therapeutic interaction comprise important sources of data upon which the science of personality must be built. In order to make reliable measurements, valid judgments, and meaningful analyses the multilevel jumble of motivations which so often characterizes personality descriptions must be organized into a systematic language.

In this chapter we will describe first a classificatory system for ordering interpersonal behavior. Then we shall present a notational system—a crude mathematic or grammar of personality—which attempts to order the levels of behavior. We shall present the units or variables by which the behavior can be measured, and five levels at which they operate.

The classificatory system allows us to measure interpersonal behavior at any of these five levels. The notational schema defines the levels and the fixed arithmetic relationships among these levels. It provides for the diagrammatic and numerical analysis of the personality structure.

The Classification System: The Interpersonal Variables of Personality

In beginning the long task of developing a personality system, the first assumption refers to the kind of behavior to be studied. We have defined this as the interpersonal core of personality. The initial step for the Kaiser Foundation research project was, therefore, to focus on this dimension of behavior. To this end a wide assortment of raw interpersonal data was assembled. Several scores of individuals—male and female, neurotic, psychosomatic, and normal—were brought into interpersonal relationships in small groups. Some of these were discussion groups in a nonpsychiatric setting. Some were psychotherapy groups in an outpatient clinic. The hundreds of interactions of each subject were observed, recorded, and studied. Many other types of interpersonal behavior were obtained from the same subjects. Their verbal descriptions of self and others—present, past, and anticipated —as expressed in the groups or as summarized in autobiographies and psychological inventories were collected. Their dreams and fantasies were recorded. Their responses on batteries of projective tests were elicited. A rich but unwieldy collection of raw materials—in the form of wire recording spools, typed transcriptions, ratings, observers' reports, test indices, projective responses—piled up for each subject. In line with our first theoretical assumption, the interpersonal aspects

of the stimulus material were taken as the focus of attention. As the research team observed this undigested mass of protocol records accumulating, the next research question occurred. How shall we analyze these data? It was clear that classificatory assistance was required. This came in the form of the second working principle, which holds that the basic data of personality are not the raw responses but the units of protocol language by which the subject's interpersonal behavior can be summarized.

The selection of this language, as we have seen, has been a crucial aspect of all personality theories. What and how many are the conceptual units of social interaction? The third working principle enters at this point, stating that measurement of interpersonal behavior requires a broad collection of simple, specific variables which are applicable to the study of adjustive and maladjustive responses.

With these guiding principles in mind, the diverse data were studied to determine the optimal number of specific variables and their orderly relationship. As a first step the interactions of the subjects were studied by three independent judges who attempted a straightforward verbal description of the interpersonal activity. In rating the observed and recorded interactions, it was noticed that transitive verbs were the handiest words for describing what the subjects did to each other, e.g., *insult, challenge, answer, help.* In rating the content of the spoken or written descriptions of self-or-other, it was noted that adjectives were more often suitable. Here we were interested in the attributes, qualities, and traits which the subject assigned to himself and others. "I am *friendly, helpful, strong*; they are *hostile, selfish, wise, helpful.*" A clear relationship seemed to exist between these two types of interpersonal description, such that the adjectives seemed to express an interpersonal attribute or potentiality for action, while the verbs described the action directly. Three rather interesting notions began to develop out of this fact. First, the relationships between different expressions of personality can be directly related to each other by grammatical or linguistic procedures. That is, what you actually *do* in the social situation as described by a verb (e.g., *help*) can be related to your description of yourself (as described by the attribute *helpful*) and to your description of your dream-self or fantasy-self (also attributive, *helpful* or perhaps *unhelpful*). These grammatical relationships became the key to a systematic consideration of the *levels of personality*, of which more later.

After extensive informal surveys of the many varieties of data, a list of several hundred terms for describing interpersonal behavior was assembled. The next task was to sort through the long lists of terms and to determine the generic interpersonal motives. Combining the

action verbs with the corresponding attributive adjectives cut down the list. Thus the adjective *insulting* was subsumed under its action category *to insult*. Next the intense and statistically rare terms were combined with the moderate and more frequent categories. For example, the themes of *murder*, *attack*, *insult*, etc., were included under the generic concept of *hostile activities*. The gradually developing lists of generic terms were then combined to eliminate overlaps and repetitions until a list of sixteen generic interpersonal motivations resulted. All of the original terms—which numbered several hundred—could be expressed as differentiated varieties of the sixteen basic interpersonal themes. In this manner the goal of breadth, specificity, and simplicity was approached.

The principle of systematic relatedness then determined the next task. This criterion demands that the variables be ordered along continua in such a way that fixed relationships exist between the elements. The question here becomes: What and how many are the dimensions along which the variables are to be scaled? In this instance, it became apparent that a two-dimensional grid was optimal for relating the variables at hand. We cannot doubt that more complex formal systems will eventually add new spatial dimensions to the organization of personality. For the present, however, a two-dimensional space offers sufficient complexity for the data and more than a sufficient complexity of methodological problems.

In surveying the list of more or less generic interpersonal trends, it became clear that they all had some reference to a power or affiliation factor. When dominance-submission was taken as the vertical axis and hostility-affection as the horizontal, all of the other generic interpersonal factors could be expressed as combinations of these four nodal points. The various types of nurturant behavior appeared to be blends of strong and affectionate orientations toward others. Distrustful behaviors seemed to blend hostility and weakness. Further experimentation and review of the raw data led to the conclusion that a circular two-dimensional continuum of sixteen generic variables represented the optimal degree of refinement of interpersonal themes. Attempts at more specific systematization of interpersonal behavior by increasing the number of variables led to difficulties in establishing clear criteria for discrimination between neighboring variables. On the other hand, use of grosser units of discrimination, e.g., only the four nodal variables, resulted in neglect of important shadings of interpersonal intent.

The sixteen generic interpersonal themes are presented in Figure 1. Each one has been assigned a code letter. Thus, Dominant behavior is classified under the letter *A*, Autonomous behavior under the letter

B, etc. Several suggestive terms are listed for each generic type of interpersonal purpose in Figure 1. Actually, there is an almost inexhaustible list of terms for each generic code letter. The many varieties of interpersonal behavior included under each category will become increasingly clear as we take up the ratings for the different levels.

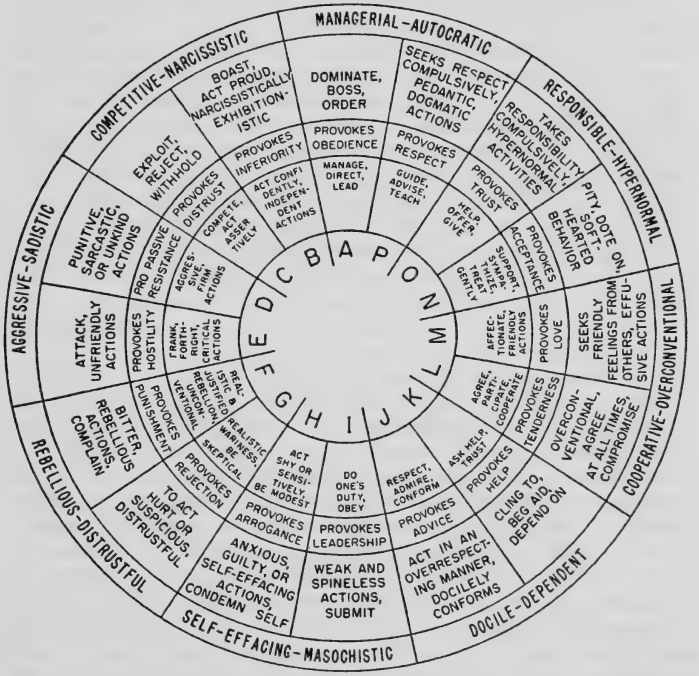


FIGURE 1. Classification of Interpersonal Behavior into Sixteen Mechanisms or Reflexes. Each of the sixteen interpersonal variables is illustrated by sample behaviors The inner circle presents illustrations of adaptive reflexes, e.g., for the variable *A*, *manage*. The center ring indicates the type of behavior that this interpersonal reflex tends to "pull" from the other one. Thus we see that the person who uses the reflex *A* tends to provoke others to *obedience*, etc. These findings involve two-way interpersonal phenomena (what the subject does and what the "Other" does back) and are therefore less reliable than the other interpersonal codes presented in this figure. The next circle illustrates extreme or rigid reflexes, e.g., *dominates*. The perimeter of the circle is divided into eight general categories employed in *interpersonal diagnosis*. Each category has a moderate (adaptive) and an extreme (pathological) intensity, e.g., *Managerial-Autocratic*.

By arranging a set of sixteen interpersonal variables along a continuum, we have implied a systematic relationship among them. If we rate any behavior as *C*, we have defined it in terms of all the other variables since *C* is one unit away from (and therefore close to) *D* and *B*, while it is eight units (and therefore quite discrepant) from *K*. The second working principle, which requires a relatedness among variables, is thus met but it is next required to demonstrate that the hypothetical relationships of these variables is related to external events. Extensive validation of the circular continuum of sixteen interpersonal variables has demonstrated that it is satisfactorily congruent with empirical facts. (5) (8) While the units around the scale are not completely equidistant, the arrangement is correctly ordered.

The selection and formal organization of variables made it possible to rate any interpersonal behavior in such a way that its relationship to all the other fifteen variables was explicit. The classificatory schema at this stage of the game was still far from complete. Only the most crude appraisals of any interpersonal behavior could be made because only the presence or absence of the theme could be indicated. For example, it was possible to say that *distrust* was present; but how much, how extreme, how inappropriate could not be measured until an intensity dimension was added.

In the most basic sense this involved making a "more or less than" judgment of the observed event. Is this behavior more distrustful than the other? The intensity dimension is quite fundamental to all human perceptions. Language and quantitative usages give us several techniques for expressing intensities: the comparative sequence *strong, stronger, strongest*, the modifying function *extremely, slightly*, as well as the intensity hierarchy of different word meanings *critical-angry-furious-enraged*. Apart from these verbal expressions, the numerical estimation of intensity (along a 3-, 5-, or 7-point scale) is accepted and common. The intensity of interpersonal activity can be rated on a linear scale ranging from absence of the behavior to extreme overreactivity. The number of differentiating points on the intensity scale can vary according to the specific purpose, but for most interpersonal responses, a 3- or 4-point graduation seems quite satisfactory.

Let us consider, by way of illustration, one interpersonal motivation as it is reflected in the intensity dimension. The power continuum (variable *A*) is conceived of as a linear scale ranging from *too much* to *complete and inappropriate absence* of dominance. When we construct an intensity scale for each of the sixteen interpersonal variables, we obtain a more differentiated form of the circular continuum which is illustrated in the concentric rings of Figure 1. The term *dominate* now takes on quite a precise meaning. It is defined as an expression of

power (*A*) which systematically relates it to the other fifteen interpersonal themes. It is further assigned an intensity loading which relates it to all other verbal terms for power as well as to every other classified word describing interpersonal interaction. In this way language of personality becomes much more exact and accessible. Every term in the English language which refers to interpersonal behavior can, in this manner, be studied, redefined systematically, and calibrated. This is not to say that these terms as used in everyday life necessarily have the same meaning to the interpersonal scientist. The general public employs all kinds of words—*force*, *power*, *efficiency*, *hostility*—which have been operationally redefined by physical or psychological scientists. The interpersonal diagnostician dealing with human communications has to keep clear the level of meaning of the words he deals with. *Anger* may denote one thing to an individual patient, another in terms of general usage, and a third in the precisely defined scientific discourse. In general, it seems best to keep the scientific meaning as close as possible to that of the general public *of the culture being studied*. The advantages of tying terminology to functional behavior rather than tying it to psychiatric usage have already been mentioned.

The two-dimensional representation of interpersonal space has many possibilities for summarizing behavior. First, it should be noted that we are rarely interested in classifying single, isolated events. Invariably we are concerned with sequences of interaction and patterns of hundreds of interpersonal expressions. The simplest and perhaps least useful way of summarizing interpersonal behavior is to plot the ratings, judgments, or units directly onto the circle. Suppose we record and then rate the interpersonal purpose involved in everything a patient does to his analyst in the first twenty hours of therapy. This would produce (depending on the consistency and expressiveness of the patient) between 1,000 and 3,000 interpersonal units. Disregarding the intensity ratings, we thus obtain the total of all Dominance (*A*) ratings and the comparable totals for the other fifteen interpersonal themes. By calibrating the sixteen radii for numerical frequency, we can then strike off points indicating the reactions for each interpersonal variable. A graphic summary of the interpersonal behavior during twenty hours of therapy is thus obtained. In Figure 2 we see that the sample patient manifested docile, cooperative dependence toward the therapist, avoiding hostility and competitiveness. Profiles based on other patients or upon this patient's behavior in the subsequent hours of treatment would allow direct, objective comparisons and the testing of hypotheses about interpersonal activity during psychotherapy.

When enough cases have been studied to provide normative data, a second and highly profitable method of summarizing interpersonal behavior is possible. There are many statistical techniques for treating each patient's scores in terms of the mean (i.e., the average) of his group. These allow us to determine one point which summarizes all

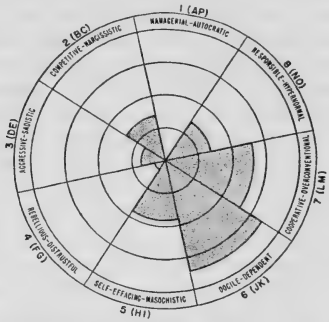


FIGURE 2. Diagrammatic Representation of Interpersonal Interaction of a Patient During Twenty Hours of Psychotherapy. Radius of circle equals 1,000 interactions. This patient manifested 820 docile-dependent interpersonal actions (*JK* octant) and 260 confident-narcissistic actions (*BC* octant).

of the interpersonal behavior in any behavioral sequence in terms of its distance and direction from the center of the circle. The latter is taken as the mean, i.e., the central tendency of the interpersonal behavior of the population studied. One method for obtaining this summary point has been described as follows:

The Interpersonal System as described so far leaves us wide latitude with respect to the formal (algebraic) properties which are to be attributed to the 16 variables. We may in fact vary the formal relationships to suit the particular context so long as we do not violate the rough intuitive specification of a circular arrangement. For example, we might think of the system as a purely ordinal array about which one specified only that categories adjacent to a given one resemble it more than do non-adjacent categories. Or we might consider the circle to be a two-dimensional array in ordinary Euclidian space, in which case conventional trigonometric and analytic formulas relate the 16 variables. After some experimentation, this latter approach was tentatively selected. Each circle was conceived to be a set of eight vectors or points in a two-dimensional space. We selected the center of gravity or vector mean of these points as a measure of central tendency.

A vector in two-dimensional space may be represented numerically by the magnitude of its components in two arbitrarily selected directions. We chose AP and LM as reference directions, giving the designations Dom and Lov

respectively to the components of the vector sum in these two directions. Representation of the eight or sixteen scores comprising a patient's circle by a single point in two-dimensional space is a considerable simplification. What is preserved in this simplification is the general tendency of the circle. What is lost are the individual fluctuations around the circle.[1]

The formulas for the two components of the vector sum are relatively evident. They are:

$$1.\ \text{Dom} = \sum_{i=1}^{16} R_i \sin \theta_i \text{ and}$$

$$2.\ \text{Lov} = \sum_{i=1}^{16} R_i \cos \theta_i$$

where R_i = the score in the 1-th category,
θ_i = the angle made by moving in counter-clockwise direction from L to the i-th category (from LM if octant scores are used).

In the present calculations, octant scores were used and .7 was taken as the value of sin 45°; the following simplified formulas resulted:

$$3.\ \text{Dom} = AP - HI + .7\,(NO + BC - FG - JK),$$
$$4.\ \text{Lov} = LM - DE + .7\,(NO - BC - FG + JK),$$

where AP = score in octant AP, etc. (4, p. 140)

It is thus possible to convert the pattern of scores on the sixteen variables into two numerical indices which locate a subject's interpersonal behavior on a diagnostic grid. Figure 3 presents the descriptive summary point for the therapy patient whose behavior has been previously diagramed in Figure 2. We note that the two summary indices place him in the JK octant; they thus become a simplified and numerical summary of the circular diagram. The vertical and horizontal lines represent varying discrepancies from the mean (the center point of the circle). We obtain in this manner a circular grid, every point on which is statistically defined. We determine the summary point of the patient's interpersonal behavior as rated by the sixteen variables in relationship to the population studied—which in this case might be a hundred randomly selected psychotherapy patients. Our subject is seen as considerably more trustful and compliant than the average therapy patient (point 1 in Figure 3).

The great advantage of the latter circular grid method of summarization is that many summary points can be graphed on the same dia-

[1] The two components of the vector sum must each be divided by $N = \sum_{i=1}^{16} R_i$ (the total around the circle all eight or sixteen scores) to get the two components of the vector mean. These latter may also be thought of as the first two Fourier coefficients of a curve fitted to the observed data. More complicated curves can be fitted by the computation of additional coefficients.

gram, facilitating comparison among levels of any individual's personality or comparisons among different individuals. Let us suppose that the psychotherapy patient we have been using for illustration shifted his interpersonal behavior markedly in the second twenty hours

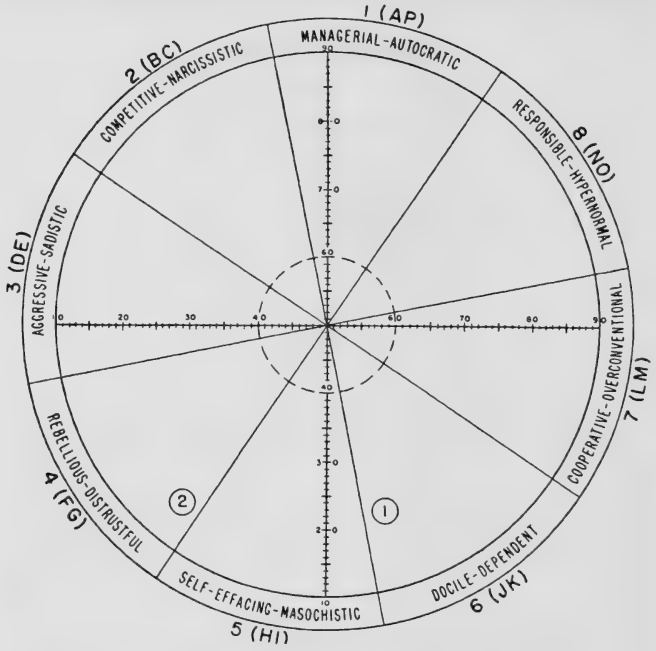


FIGURE 3. Diagram Summarizing the Interpersonal Behavior of Patient During First Twenty Hours ① and the Second Twenty Hours ② of Psychotherapy. Summary points are located by intersection of horizontal and vertical indices. The indices are determined by the raw number of interactions converted to vector scores by the trigonometric formulas described on page 69.

of treatment, expressing disappointment and distrust towards the analyst. The several thousand interactions are rated, statistically summarized, and graphed as point 2 on Figure 3. A diagrammatic condensation of the changing behavior of the patient (based on quantitative objective methods) becomes available. This patient has shifted his interpersonal behavior in therapy. He was compliant (point 1)

during the initial stage of treatment but became passively hostile and withdrawn in the second stage of therapy. Later changes in the treatment relationship can be similarly plotted—always in relationship to the average of the population.

Previous Suggestions for a Two-Dimensional Classification of Personality Traits

The notion of classifying human emotions in terms of four systematically related variables is certainly not novel. The history of psychology provides several interesting correspondences to the present system of arranging data in terms of the four nodal points.

The four quadrants of the interpersonal system comprise blends of the nodal dichotomies: love versus hate and power versus weakness. The four "blended" quadrants fit rather closely the classical humors theory of Hippocrates. The upper left quadrant (hostile strength) equates with the choleric temperament, the lower left (hostile weakness) with the melancholic, the lower right (friendly weakness) with the phlegmatic, and the upper right (friendly strength) with the sanguine.

The same fourfold classification reappears in Freudian thought. Freud's treatment of the individual stresses two basic motives—love and hate. His theories of social phenomena and group interaction, on the other hand, emphasize domination, power, and the interaction of the weak versus the strong. In his open letter to Einstein "Why War?" these two avenues of Freud's thought intersect and illustrate his commitment to the four concepts. He presents his power theory first:

> Such then, was the original state of things: domination by whoever had the greater might—domination by hate violence or by violence supported by intellect. (2, p. 275)

In the following paragraph he says:

> The situation is simple so long as the community consists only of a number of equally strong individuals. . . . But a state of rest of that kind is only theoretically conceivable. In actuality, the position is complicated by the fact that from its very beginning the community comprises elements of unequal strength —men and women, parents and children—and soon, as a result of war and conquest, it also comes to include victors and vanquished, who turn into masters and slaves. The justice of the community then becomes an expression of the unequal degrees of power obtaining within it; the laws are made by and for the ruling members and find little room for the rights of those in subjection. From that time forward there are two factors at work in the community which are sources of unrest over matters of law but tend at the same time to a further growth of law. First, attempts are made by certain of the rulers to set themselves above the prohibitions which apply to everyone—they seek, that is, to go

back from a dominion of law to a dominion of violence. Secondly, the oppressed members of the group make constant efforts to obtain more power and to have any constant efforts to obtain more power and to have any changes that are brought about in that direction recognized in the laws—they press forward, that is, from unequal justice to equal justice for all. (2, pp. 276–77)

Later, in the same paper, Freud goes on to summarize his familiar theories of individual motivation.

According to our hypothesis human instincts are of only two kinds: those which seek to preserve and unite—which we call "erotic," exactly in the sense in which Plato used the word "Eros" in his Symposium, or "sexual" with a deliberate extension of the popular conception of "sexuality"—and those which seek to destroy and kill and which we class together as the aggressive or destructive instinct. As you see, this is in fact no more than a theoretical clarification of the universally familiar opposition between Love and Hate which may perhaps have some fundamental relation to the polarity of attraction and repulsion that plays a part in your own field of knowledge. We must not be too hasty in introducing ethical judgments of good and evil. Neither of these instincts is any less essential than the other, the phenomena of life arise from the operation of both together, whether acting in concert or in opposition. It seems as though an instinct of the one sort can scarcely ever operate in isolation; it is always accompanied—or, as we say, alloyed—with an element from the other side, which modifies its aim or is, in some cases, what enables it to achieve that aim. Thus, for instance, the instinct of self-preservation is certainly of an erotic kind, but it must nevertheless have aggressiveness at its disposal if it is to fulfill its purpose. So, too, the instinct of love, when it is directed toward an object, stands in need of some contribution from the instinct of mastery if it is in any way to possess that object. The difficulty of isolating the two classes of instinct in their actual manifestations is indeed what has so long prevented us from recognizing them.

If you will follow me a little further, you will see that human actions are subject to another complication of a different kind. It is very rarely that an action is the work of a *single* instinctual impulse (which must in itself be compounded of Eros and destructiveness). In order to make an action possible, there must be as a rule a combination of such compounded motives. This was perceived long ago by a specialist in your own subject, a Professor G. C. Lichtenberg who taught physics at Gottingen during our classical age—though perhaps he was even more remarkable as a psychologist than as a physicist. He invented a Compass of Motives, for he wrote. "The motives that lead us to do anything might be arranged like the thirty-two winds and might be given names on the same pattern: for instance, 'food-food-fame' or 'fame-fame-food'. So that when human beings are incited to war they may have a whole number of motives for assenting—some noble and some base, some of which they speak openly and others on which they are silent. There is no need to enumerate them all. A lust for aggression and destruction is certainly among them: the countless cruelties in history and in our every day lives vouch for its existence and its strength. The gratification of these destructive impulses is of course facilitated by their admixture with others of an erotic and idealistic kind." (2, pp. 280–82)

The similarity between these suggestions for a "Compass of Motives" and the circular classificatory system described in this book is so close as to require no further comment.

In addition to these earlier approaches to a fourfold classification system of human motives, other similar conceptual schemes have been developed contemporaneously with (and independently of) the interpersonal system.

The interpersonal system, it will be recalled, was developed from the rawest kind of empirical approach. It can be said that the patients in the earliest pilot study group developed the interpersonal circle by providing the varied pool of interpersonal responses which were gradually refined into the present circular continuum. It is most interesting, therefore, that the results of our empirical studies tend to confirm hypotheticated fourfold classifications independently proposed by other writers.

Ross Stagner, for example, in 1937 presented a two-dimensional representation of behavior which has a certain similarity to the interpersonal "compass." Stagner wrote: "The hypothesis which we wish to present is that the directions of variability in human behavior are very limited in number, present evidence suggesting that there are only two dimensions along which such variations may be plotted. These two dimensions may be considered: 1) approach to or withdrawal from a stimulus object; and 2) increased or decreased organismic activity with reference to the object." (11, p. 52)

Although Stagner is noninterpersonal in his variable system and, perhaps, overly optimistic about the simplicity of direction and motivation, his paradigm attracts our interest for two reasons: First, it is remarkably similar to the interpersonal circular system. Secondly, it is close to the spatial theory of the genesis of interpersonal relations which we have discussed in the preceding pages.

Talcott Parsons, who is perhaps the most sophisticated and systematically mature sociological writer of our generation, has described a conceptual method which he calls the "paradigm of motivational process." He states that this

> . . . started with the assumption that a process of interaction which has been stabilized about conformity with a normative pattern structure, will tend to continue in a stable state unless it is disturbed. Concretely, however, there will always be tendencies to deviance, and conversely these tendencies will tend to be counteracted by re-equilibrating processes, on the part of the same actor or of others.
>
> It was furthermore maintained that neither the tendencies toward deviance nor those toward re-equilibration, that is, toward "social control" could occur in random directions or forms. Deviance was shown to involve four basic

directions, according to whether the need was to express alienation from the normative pattern—including the repudiation of attachment to alter as an object—or to maintain compulsive conformity with the normative pattern and attachment to alter, and according to whether the mode of action was actively or passively inclined. This yielded four directional types, those of aggressiveness and withdrawal on the alienative side, and of compulsive performance and compulsive acceptance on the side of compulsive conformity. It was furthermore shown that this paradigm, independently derived, is essentially the same as that previously put forward by Merton for the analysis of social structure and anomie. (9, p. 68)

Thus, we see that two productive sociologists, Parsons and Merton, although working from somewhat different subject matters and frames of reference, have arrived at solutions for categorizing human interaction which are close to the interpersonal circle.

Another very interesting correspondence has developed from the researches of George T. Lodge. Lodge has developed some promising applications of the Haskell Coaction technique to psychological measurement. This is a method for plotting the resolution of two coacting variables in terms of a two-dimensional surface. The coaction compass functions exactly as the interpersonal circle, and the standard trigonometric solutions of coaction variables have been applied by Haskell and Lodge to their data in the same manner as La Forge's formulas for the interpersonal system.

Lodge describes his use of the Haskell Coaction Compass method as follows:

The *Coaction Compass* as formulated by Edward F. Haskell is a general conceptual scheme which is beginning to find wide applications in biological and social science. This compass is a Cartesian coordinate frame strictly comparable to the mariner's wind rose. Its use permits assignment of vector magnitudes to the resultant forces from any two interdependent power systems, and their subsequent treatment by methods of analytic geometry. In the field of Clinical Psychology, it is convenient to view the processes of inhibition and facilitation as representing two such coacting power systems. It is not our purpose at present to go into the details of a coaction theory of personality as such. We have attempted a preliminary formulation of such a theory elsewhere. Here, we shall try only to set forth certain necessary steps for the interest of those who may wish to apply coaction reasoning in their analyses of Rorschach protocols. . . .

The Rorschach method lends itself readily to the study of personality in terms of a coaction formulation, at least insofar as consideration of the scoring of determinants is concerned. If the form level of a response be regarded as reflecting the strength of the inhibitory process, and if the amount of expression of color, shading, and movement be regarded as reflecting the level of manifest affect or facilitation, the response may be represented geometrically as a resultant vector determined by the relative strengths of the two coacting power systems. (6, pp. 67–68)

The Variability of Interpersonal Behavior

Employing the continuum of sixteen variables, summarized numerically, it is possible to make three different types of systematic studies of the same person. We can investigate the interpersonal behavior of one individual at many levels of his personality. Charting the measurements for all aspects of behavior on the same circular grid provides a systematic pattern diagnosis of the *structure* of personality at one time. By adding summaries of the same measurements as they change in time, we obtain a picture of *temporal* variation in the multilevel pattern of personality. In the preceding example we have noted such a temporal change in one level of personality—interpersonal behavior in one cultural context, the psychoanalytic sessions. A third use of the circular continuum is to chart the varying patterns of behavior in different interpersonal situations. How does the patient behave with his boss, with his wife, with his children?

These measurements of behavior, at different levels, at different times, and in different situations comprise the basic patterns and changing processes of personality. They are called *structural*, *temporal*, and *situational* variation patterns, respectively. Temporal variation—the changes in personality patterns over time—has extreme functional importance since our prediction about future developments (e.g., prognosis for psychotherapy) is involved. Situational variation refers to the cultural relativity of interpersonal relationships. Structural variation refers to the relationship among the levels of personality and brings us to the basic issues of the notational system—the organization of personality into levels.

The Formal Notational System: The Levels of Personality

The fact that behavior exists at more than one level of awareness has been intuitively recognized for centuries. The discovery of unconscious motivation—in the sense of a formal theoretical statement—was first made by Sigmund Freud.

This was an epochal landmark in the study of personality and human nature.

The neat personality structures of rationalistic psychology were exploded into an untidy disarray. It is no longer possible to depend on the solid validity of the subject's conscious report. If the subject in a perception experiment judges one stimulus object as larger than another, it may have to do with the physical aspects of perception—but it may also reflect a desire to agree or disagree with other subjects, to assist or frustrate the experimenter's purpose (as he imagines it to be).

The concept of levels destroys the simple, unidimensional notions of behavior determined by chains of stimulus-response reactions. All the major learning theories since Freud, however cognitive and physicalistic they may strive to be, have by necessity taken into account this multidimensional quality of motivation. The complexity of human nature for the first time begins to command adequate conceptual respect.

Accompanying the early positive rewards of the "unconsciousness theory" is a series of premature, intuitive concepts and logical fallacies. To deal with some of these illogical procedures, we have stated in the fifth working principle that any statement about human behavior must indicate the level of personality data to which it refers.

When this postulate was applied to the varied mosaic of miscellaneous protocols obtained from the pilot study cases, the first task required was to classify them into discrete levels. The questions then became: How many levels of personality should be employed? What are they? And how shall they be defined?

Any solutions to these problems must be arbitrary, formal decisions. That is, we must assume no divinely instituted or platonically ideal number of personality divisions. In selecting the number of levels. we are limited on the broad side by the practicalities of the empirical method and on the narrow side by theoretical adequacy, that is (at this primitive state of our knowledge), if we have too many levels, the permutations and combinations of the interlevel relationships become impossibly unwieldy. If we have too few, important nuances become lost by being compressed into general categories.

After reviewing the many types and sources of personality data, a classification into five levels was found to be the most effective. This decision is a notational procedure which seems to meet the functional criteria of the present time. When we say that it is convenient to conceive of five levels of personality, we do not imply that there is "really" or "eternally" such a structural division. Early psychoanalytic writers naïvely tended to imply, and the uncritical reader tended to assume, that there "really were" two or three levels of personality in the same sense that there "are" five fingers on the hand. When the formal nature of these divisions of consciousness was not made explicit, a metaphysical language threatened to develop. At this point we designate five levels of personality data which we suggest are the most profitable for research, theory, and functional prediction.

These five general levels of personality data are: I. the Level of Public Communication; II. the Level of Conscious Description; III. the Level of Private Symbolization; IV. the Level of the Unexpressed Unconscious; and V. the Level of Values. These levels are defined in

terms of the operations which produce the pertinent data. That is, the source of the data automatically determines the level of classification. In this way we obtain operational definitions of the five levels of personality.

There are many different specific kinds of expression which can contribute data to any one level. For example, there are several ways in which fantasy symbols can be manifested—dreams, projective tests, fantasies, etc. All of these produce Level III data, although the operations by which the themes are expressed are quite separate. In order to insure clarity and precision we always indicate (by code) the specific source of the data. The general level is designated by a roman numeral and the sublevel operations are designated by a code letter. Level III-D, for example, means private interpersonal symbols obtained from dreams. Level III-T indicates private interpersonal symbols obtained from TAT stories. The general definition of levels and the specific test and rating procedures by which they are measured will now be presented.

Level I (*Public Communication*) consists of the overt behavior of the individual as rated by others along the sixteen-point circular continuum. These judgments are made by trained observers or by naive fellow subjects who observe the subject in interpersonal situations. They rate his interpersonal impact as it appears to them. What we obtain is a series of ratings of the interpersonal effect the subject has on others who share social situations with him. Other estimates of Level I behavior are obtained from special test procedures—situation test, prediction scales and the like.

Level I data is objective or public—rather than private or subjective. It may or may not agree with the subject's own view of the situation. To obtain Level I data it is necessary to have the subject involved in social interaction and to have others rate their view of his purposive behavior. This gives a measurement of his social "stimulus value." Other specialized methods for assessing Level I require the patient to take criterion-specific tests (like the MMPI) which allow us to predict his interpersonal role.

The situation in which we rate interpersonal behavior can be an extraclinic event or it can be restricted to the more controlled environment of the clinic or assessment situation. The raters can be researchers, diagnostic or therapeutic clinicians, fellow patients, or family members. The meaning of the Level I rating thus depends on the cultural context and the category of the rater. These differences provide interesting sublevel variations of the broad, general Level I of Public Communication.

There are five methods which provide estimates of Level I public behavior. These are coded as follows:

Level I-M: MMPI indices which reflect the interpersonal pressure exerted on the clinician by the patient's symptoms.
Level I-R: Ratings by trained personnel of the patient's minute-by-minute behavior in a social situation.
Level I-S: Sociometric ratings (from check lists) by fellow patients or by trained observers.
Level I-P: MMPI indices which predict the interpersonal behavior to be expected in group psychotherapy.
Level I-T: Scores from standard situational tests which assess the patient's interpersonal reactions.

The following chapter is devoted to a detailed description of the implications, measurement, and validation of Level I behavior.

Level II (*Conscious Descriptions*) includes the verbal content of all the statements that the subject makes about the interpersonal behavior of himself or "others." His descriptions of himself and others are obtained from a variety of sources—conversations, therapy protocols, autobiographies, check lists. They are then rated along the same sixteen-point circular continuum. We are interested here in the subject's reported perceptions of himself and his interpersonal world. We are not interested at this level in the consensual accuracy of these perceptions or in the potential deeper meanings. We are concerned only with the phenomenological field—the way in which the subject reports his view of self and world. It must be noted that one single sentence expressed by a subject can provide both a Level I and a Level II rating. If a patient says, "I am a responsible person," the Level II rating reflects the surface meaning of responsibility (coded as *O*) reported by the subject. Observers of the interpersonal context in which the sentence was uttered might agree that its Level I-R effect was to establish autonomy from the therapist (coded *B*) or superiority over other patients (also coded *B*). The reported self-perception usually is different from the interpersonal impact on or meaning to others.

There are four methods which provide data for Level II descriptions of self and others. These are coded as follows:

Level II-Di: Ratings by trained personnel of the verbal content from diagnostic interviews.
Level II-Ti: Ratings by trained personnel of the verbal content from therapy interviews.
Level II-C: Scores from the Interpersonal Adjective Check List on which the patient checks his view of self and others.
Level II-A: Ratings by trained personnel of the content of autobiographies written by patients.

The illustration, implications, use, and validation of this level of conscious description will be considered in Chapter 8.

Level III (*Private Symbolization*) consists of projective, indirect fantasy materials. These data come from a variety of sources—dreams, fantasies, artistic, or autistic productions, projective tests—which elicit imaginative expressions. The interpersonal themes of all these symbolic expressions are rated by two or more trained raters along the sixteen-point circular continuum. We thus possess a technique for systematically measuring the indirect autistic data of personality in terms of the same interpersonal variables which we use to categorize the public or conscious aspects of behavior. The broad general nature of the level categories must be mentioned again. There are many sublevel varieties of symbolic data. Some creative, projective tests, for example, may be more closely related to the level of conscious description. Others may be consistently identified with the pattern of dream themes. The exact "depth" of any symbolic response depends on a variety of factors—cultural context, type of symbolic stimulus, the nature of the Level I behavior at the time, etc. The detailed systematic organization and specific differentiation of these private productions becomes one of the most important and fascinating problems of current dynamic psychology.

There are at present seven methods for collecting Level III preconscious data from patients. These are coded as follows:

Level III-T:	Ratings of TAT stories.
Level III-IFT:	Ratings from the Interpersonal Fantasy Test.[2]
Level III-i:	Ratings of responses to the Iflund projective test. (3)
Level III-B:	Ratings of responses the Blacky projective test. (1)
Level III-D:	Ratings of interpersonal themes in dream protocols.
Level III-F:	Ratings of interpersonal themes from waking fantasies expressed by the subject.
Level III-M:	MMPI indices which predict to preconscious behavior.

There is one distinction to be made in dealing with preconscious data that is most important. This is the division between the hero and the world personages in fantasy productions. Evidence from several samples suggests that clearly different sublevels of behavior are involved.

[2] The Interpersonal Fantasy Test is a Level III instrument developed by the Kaiser Foundation psychology research project to fit the interpersonal system. It is a TAT-type test in which the cards are designed to explore systematically the subject's fantasies about interpersonal relationships between heroes and paternal, maternal, cross-sex, and same-sex figures. Scores are obtained for Level III Self, Mother, Father, Cross-sex and Therapist.

These findings are of considerable value because they define two distinct sublevels of the symbolic or preconscious area. One is designated *Level III Hero.* This is the symbolic self-image. Its theoretical and clinical meaning is different from the preconscious images of the symbolic world. This latter area is designated *Level III Other.* These two subdivisions of symbolic expression have been found to be lawfully distinct. They often define different kinds of interlevel conflict and different personality types, and they are related to different symptomatic pictures. Chapter 9 which is devoted to Level III symbolic behavior will consider these distinctions.

Level IV (*the Unexpressed Unconscious*) is defined by the interpersonal themes which are systematically and compulsively avoided by the subject at all the other levels of personality and which are conspicuous by their inflexible absence. Here we refer to those activities which are consistently and deliberately "not present" in the personality profile. These "unexpressed" aspects of personality are as yet unexplored. For this reason, this level will not be employed in the basic systematization that follows.

The definition of Level IV is a problem as yet unsolved. The most convincing demonstration of the presence of motivation previously unexpressed (at the other three levels) would require two parallel sets of evidence. The negative proof would involve statistical demonstration that the subject significantly avoids certain patterns of interpersonal response with a frequency far beyond the expectations of chance. The proof positive requires that the same interpersonal themes be picked up in significant frequency by certain subliminal, indirect perceptual tests, e.g., abnormally long reaction times or perceptual distortions in response to thematic stimuli presented at split-second (blurred) tachistoscope exposures. The implications and problems involved in the unexpressed behavior of Level IV will be surveyed in Chapter 10.

Level V (*Values*) consists of the data which reflect the subject's system of moral, "superego judgments," his ego ideal. We refer here to the interpersonal traits and actions that the subject holds to be "good," proper, and "right"—his picture of how he should be and would like to be. These idealized interpersonal themes are obtained in the same manner as the conscious descriptions of Level II. We single out from interview, free association, check list, and questionnaire the expressions which concern his value-feelings. These are rated and scored according to the sixteen-point circular continuum.

Like the other levels of personality, the "ego ideal" cannot be conceived of as a unitary or narrowly defined category. Some "values" may be consciously expressed—others may be rated as they appear

in implied form. Thus some may be "deeper" than others. There are three methods for obtaining Level V ratings of the ego ideal. These are coded as follows:

Level V-C:	Scores from the Interpersonal Adjective Check List on which the patient checks his ego ideal.
Level V-Di:	Ratings by trained personnel of the subject's ideals as expressed in diagnostic interviews.
Level V-Ti:	Ratings by trained personnel of the subject's ideals as expressed in therapy interviews.

The measurement and meaning of this level of behavior will be discussed in Chapter 11.

There follows in Table 1 a summary of the various sources of data for each level and sublevel of personality. We should observe again that the assignment of data to the appropriate level operates automatically. The source of the data routinely and rigidly defines the level. It should also be noted that while our method is rigid, behavior is flexible and fluid, and does not always follow our notational schemes. By this we mean that there exist sublevel variations; some Level II

TABLE 1

Operational Definition of Five Levels of Personality According to Source of Data

Level I: (Public Communication) This level concerns the interpersonal impact of the subject on others—his social stimulus value. There are four different ways of obtaining this measure:

Level I-R:	Ratings by trained personnel of the patient's minute-by-minute behavior in a social situation.
Level I-S:	Sociometric ratings (from check lists) by fellow patients or by trained observers.
Level I-M:	MMPI indices which predict the interpersonal behavior to be expected.
Level I-T:	Scores from standard situational tests which assess the patient's interpersonal reactions.

Level II: (Conscious Descriptions) The subject's view of self and world obtained from interviews, autobiography, check list, questionnaire. There are four methods which provide data for this level:

Level II-Di.	Ratings by trained personnel of the verbal content from diagnostic interviews.
Level II-Ti:	Ratings by trained personnel of the verbal content from therapy interviews.
Level II-C:	Scores from the Interpersonal Adjective Check List on which the patient checks his view of self and others.
Level II-A:	Ratings by trained personnel of the content of autobiographies written by patients.

Level III: (Preconscious Symbolization) The subject's autistic, projective fantasy productions. There are two sublevels of preconscious expression: Level III Hero and Level III Other.

Level III Hero is defined by the interpersonal themes attributed to the heroes of preconscious protocols obtained from dreams, fantasies, projective stories

Level III Other comprises the interpersonal themes attributed to the "other" figures from the same preconscious protocols.

There are at present seven methods for collecting Level III data:

Level III-T	Ratings of TAT stories.
Level III-IFT:	Ratings from the Interpersonal Fantasy Test.
Level III-I:	Ratings of responses to the Iflund projective test.
Level III-B:	Ratings of responses to the Blacky projective test.
Level III-D:	Ratings of interpersonal themes in dream protocols.
Level III-F:	Ratings of interpersonal themes from waking fantasies expressed by the subject.
Level III-M:	MMPI indices which predict preconscious behavior.

Level IV: (Unexpressed Unconscious) This level is defined by two criteria: the interpersonal themes significantly omitted at the top three levels and significantly avoided on tests of subliminal perceptions, selective forgetting, and the like. Specific methods for obtaining this data are not yet developed.

Level V: (Ego Ideal) This level comprises the subject's statements about his interpersonal ideas, standards, conceptions of good and evil as obtained in interview, autobiography, questionnaire, or check list. There are three methods for obtaining Level V ratings of values:

Level V-C:	Scores from the Interpersonal Adjective Check List on which the patient checks his ego ideal.
Level V-Di:	Ratings by trained personnel of the subject's ideals as expressed in diagnostic interviews.
Level V-Ti:	Ratings by trained personnel of the subject's ideals as expressed in therapy interviews.

reports (let us say from the intense confidence of psychotherapy) turn out to be much closer to our Level III measurements. Some symbolic productions (Level III) from subjects who are striving to "overload" their presentations in one thematic direction may duplicate Level II conscious reports. These sublevel shifts are generally due to differences in the social situation, or in the stimulus materials, or general variability factors such as time, oscillation, and interlevel dynamics. All of these are, fortunately, open to some systematic measurement and predictive control, and will be treated in a later publication.

To conclude this preliminary glance at the five defined levels of personality, an illustration of the way data are assigned to levels may prove helpful. If a subject is rated as displaying aggressive behavior in a unit of interpersonal action, the rating of hostility (*E*) is then coded into the matrix of Level I-R variables. Should this same subject describe himself in a conscious report (on a check list) as friendly and agreeable, a Level II-C rating of affiliation (*M*) would be made. Should he report a dream in which the hero behaves in a submissive, trustful fashion, dependence (*K*) would be coded into the Level III-D pattern. Should nurturant behavior be absent from all of these three levels (to a statistically significant degree), and if it appears in the

form of exaggerated avoidance or distortion of *tenderness* themes on Level IV measuring devices, then the presence of Level IV nurturance (*N*) could be inferred. If his description of his "ego ideal" on the check list stresses the themes of power and independence, then the Level V-C scores of *A* and *B* are emphasized.

Let us assume that hundreds of additional measurements at all levels continue to emphasize the same pattern. The summary totals for each level are converted to standard scores, comparing them to the means of appropriate normative larger samples of cases. By means of the vector method described above we can chart the personality structure in the form of a diagram summarizing five levels of self-behavior. The data from each level has been converted into a systematic rating language which is standardized, and directly comparable with the data from other levels. The many implications and theoretical aspects of this multidimensional organization of personality will be discussed in Chapter 13.

The Measurement of the Self-Other Interaction

A final notational procedure remains before the basic elements of the personality structure can be assembled. Formal recognition must be made of the fact that any interpersonal behavior involves more than one person—and by definition cannot be considered as an isolated phenomenon. We accepted (in the fourth working principle) the premise that the interpersonal theory logically requires that for each variable or variable system by which we measure the subject's behavior, we must include an equivalent set for measuring the parallel behavior of the subject's interpersonal world.

The reciprocal nature of social interaction, the reflex way in which human beings tailor their responses to others, and the automatic way in which they force others to react to them will become one of the main points of emphasis in this book. To take systematic account of these interchanges (at all levels of personality) a notational step is required. This is accomplished by categorizing and summarizing *separately* the interpersonal responses of the subject and the specific others with whom he interacts. When we observe the subject's public communications at Level I we rate not only his purposive behavior, but also what others do to him. Then we score the patient's interpersonal responses to the psychotherapist and we also score the latter's reactions toward the patient. We note, for example, that the subject acts dependent (*K*) and the therapist reacts with nurturance (*O*).

When we measure the subject's conscious reports at Level II, we rate not only his perceptions of himself, but also his descriptions of his interpersonal world as he views it. Thus we score the interpersonal

themes the patient attributes to himself and, in addition, the themes he attributes to the specified "others" with whom he is concerned. We rate, for example, the subject's statement "I am helpless to solve this problem" (*J*) and his description of the therapist "You are a person who can help me with my problem" (*O*). When we summarize his Level II material, we obtain a numerical or diagrammatic total for the reported view of self, his view of his therapist, of his family members, of the other members of his therapy group, and all "others" he has described.

When we deal with the symbolic data of Level III, we rate not only his fantasy themes attributed to self or to self-identified heroes, but also the interpersonal themes he assigns to the "others" with whom his fantasy self interacts. The subject might report, for example, a dream in which he attacks (*E*) his rejecting unsympathetic psychotherapist (*C*). We summarize the Level III fantasy materials in the same manner—obtaining separate totals from his symbolic self and symbolic others.

The usefulness of this self-other classification for the unexpressed themes of Level IV is, at present, an unsettled question. Some psychologists hold that the vague, diffuse themes from the less conscious areas of personality cannot be differentiated into self-other categories. Since there is no adequate data to settle this question, Level IV behavior will not be formally systematized in this book.

The division of behavior into self-and-other does not seem to apply as directly to the "value" data from Level V. It might be assumed that the "ego ideal" or superego judgment of what's "right-and-good" holds as a general value system for one's view of self and all others. On the other hand, it is possible to obtain measurements on the "ideal-for-self" and the "ideal-for-specified-others." Thus the subject might be asked to describe his view of the "ideal" mother, the "ideal" father, the "ideal" spouse, the "ideal" therapist, the "ideal" boss, etc. The Kaiser Foundation research project is at this time conducting investigations of this sort, but the results are not yet tabulated. For this reason in this book, Level V will be considered as a unitary field and will not be divided into self and other.

Variability Indices: The Organization of Personality

The interpersonal system deals, therefore, with eight generic areas of personality data: two each (self and other) for Levels I, II, III, and one each for Levels IV and V. Since Level IV has been omitted from consideration in the current research, we shall be considering in the following chapters seven generic areas of behavior. A

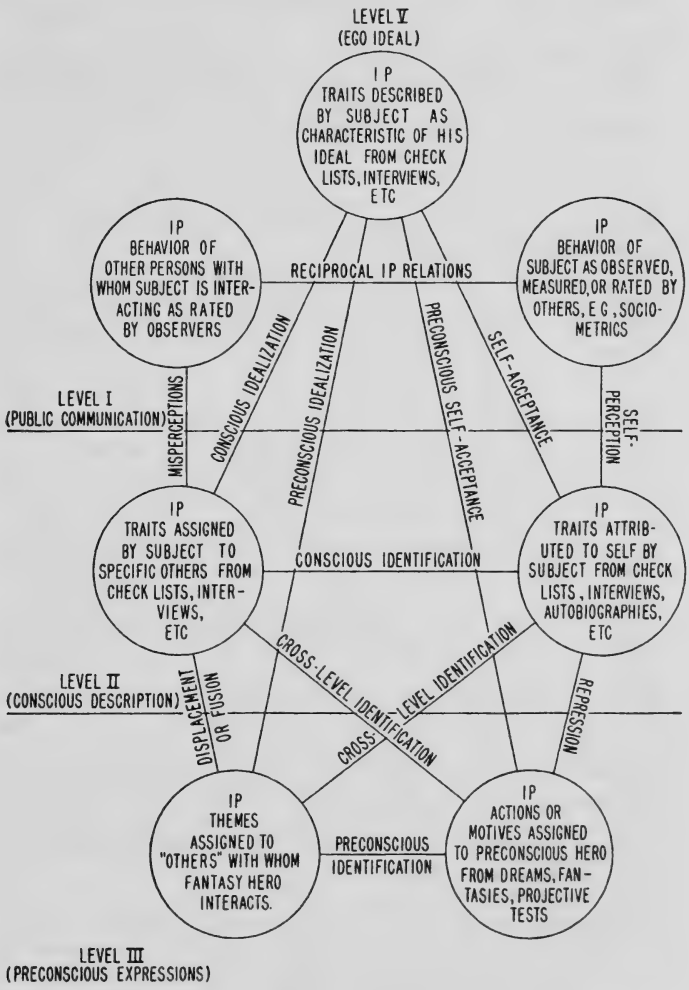


FIGURE 4. Schematic Diagram Illustrating Seven Generic Areas of Personality at Four Levels and Listing Some Variability Indices of Personality Organization.

preliminary diagram of personality structure can now be presented. Figure 4 illustrates the generic division of personality data with which we are concerned. Each of the seven circles denotes a generalized classification of personality data. Inside each circle is printed a suggestive list of the sources of data for each level. This is a schematic, pictorial representation summarizing the notational procedures thus far outlined. It is highly generalized. As it stands here it could not be used for clinical or research purposes since only one circle for "others" is represented. In practice we would have as many "others" circles as necessary to summarize the interpersonal behavior of each person with whom the subject interacts.

More practical and accurate working diagrams are presented in the clinical and diagnostic chapters to follow. The stylized diagram in Figure 4 is presented to point up the next organizational issue, the relationship among the levels of personality. It will be noted that a series of lines connects the seven circles in Figure 4. These represent the dynamic interactions among the levels. Each circle, it will be remembered, summarizes the pattern of standard scores on the same matrix of sixteen variables. We can, therefore, make direct mathematical comparison between levels. The line between Level II Self and Level III Self stands for the subtractive comparison between the two areas of personality, and indicates how similar or different they are. In addition, it provides a numerical statement of those interpersonal themes which appear in private symbolization and which are not consciously attributed to self. These relationships among levels are called *intrapersonal variability indices.* They are, in some respects, operational redefinitions of certain Freudian "defense mechanisms," since they systematically summarize the comparisons among the levels of personality. The Freudians call these interlevel relationships "defense mechanisms" because they are seen as "warding off" instinctual impulses. We have, however, in principle hesitated to accept this focusing on the unconscious level of behavior and have accepted instead an emphasis on the over-all organization of all levels. We have tended to see these interlevel relationships simply as indices which reflect the structure of personality organization and the kind and amount of conflict, or rigidity, or flexibility.

We therefore call these relationships among the areas of behavior *variability indices.* They reflect in mathematical terms the tendency of any one level to duplicate or balance the inevitable distortions of the other levels of personality. The definition, meaning, and function of these generic mechanisms of organization will be discussed in Part III of this book.

Summary

This chapter, by way of overview and prospectus, has presented a classificatory system for ordering interpersonal behavior. Five levels at which this behavior exists have been defined. A brief survey of the system of variability indices which link together these levels has been included.

The subsequent chapters will be devoted to a detailed filling-in of the broad areas outlined in this chapter. The next six chapters will deal with the levels of personality—theory, measurement, methodology, and meaning of the varieties of interpersonal behavior. Chapter 13 will deal with the variability dimension—and will present definitions of the specific interlevel relations involved in the formal notational system.

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II

The Interpersonal Dimension of Personality: Variables, Levels, and Diagnostic Categories

Introduction

The following section of this book is devoted to a discussion of interpersonal behavior at five levels of personality. These levels are:

I. The Level of Public Communication
II. The Level of Conscious Communication
III. The Level of Private Communication
IV. The Level of the Unexpressed
V. The Level of Values

A chapter is devoted to each of these levels. Each chapter includes a historical review of previous theories relating to the level in question, an operational definition of the level, a system for measuring behavior at the level, and a discussion of its significance. Considerable theoretical speculation as to the meaning of behavior at each level will be included. In order to preserve the descriptive and theoretical orientation of the book we have not included a detailed account of the research findings. Where there is evidence supporting these speculations, reference will be made to the scientific publication in which the pertinent research has been described.

This section is concluded by a description of the system of interpersonal diagnosis (Chapter 12). Here we employ the data from three levels of behavior to construct an objective multilevel diagnostic system.

7

The Level of Public Communication: The Interpersonal Reflex

This chapter takes as its subject interpersonal communication. This aspect of personality, which we have designated Level I, is concerned with the social impact that one human being has on another. We shall consider first some methods for isolating and defining these interactions, and then proceed to their implications for personality theory.

The events studied at this level are the overt interpersonal activities of the individual. What a person does in any social situation is a function of at least two factors, (1) his multilevel personality structure and (2) the activities and effect of the "other one," the person with whom he is interacting.

In order to define and to discuss the level of overt communication it is necessary at times to tear it out of these two broader contexts in which it is always imbedded. The criteria of logical narration demand that we talk about interpersonal behavior in this chapter as though it exists apart from the other aspects of the person's personality structure or apart from the behavior of others. These broader contexts are always implicitly referred to and should be kept in mind.

Definitions and Illustrations

The basic unit involved here is the interpersonal effect. We determine the interpersonal meaning of any behavior by asking, "What is this person doing to the other? What kind of a relationship is he attempting to establish through this particular behavior?" The answers to these questions define the subject's interpersonal impact on the other one. For example, "He is boasting and attempting to establish superiority"; or, "He is rejecting and refusing to help."

We are concerned at this level with *what* one person communicates to another. A father, for example, may employ one or one thou-

sand words to refuse his child's request. The mode, style, and content of the two rejecting expressions may be very different, but their interpersonal effect is the same—rejection.

In studying the interpersonal purposes which underlie human behavior, the following hypothesis has developed. It seems that in a large percentage of interactions the basic motives are expressed in a reflex manner. They are so automatic that they are often unwitting and often at variance with the subject's own perception of them. This facet of behavior is therefore a difficult one to isolate and measure. It is often unverbalized and so subtle and reflex as to escape articulate description. Sometimes these interpersonal communications can be implicit in the content of the discussion: Grandfather talks incessantly about the lack of energy and initiative of modern youth in order to impress others with the fact that he is a successful, self-made man. Grandmother talks incessantly about sickness, calamity, and death to remind others that the time may be short to repay her for the sacrifices she has made for her children. Grandfather never says openly, "I am better than you young people." Grandmother never says, "You should feel guilty and devoted to me." Grandfather's remark may be concerned with the issue of the 40-hour week. Grandmother may be quoting from the obituary column of the evening paper. Behind the superficial content of these expressions are the repetitive interpersonal motives—superiority and reproach. Behind the superficial content of most social exchanges it is possible to determine the naked motive communications: I am wise; I am strong; I am friendly; I am contemptuous; as well as the concomitant messages: you are less wise, less strong, likable, contemptible. Jung has described the "persona" as a mask-like front behind which more basic motives exist. The purposive behavior we are dealing with in this chapter is similar, but in emphasis something more important than just a social façade. It is closer, perhaps, to the "character armour" concept from the earlier writings of Wilhelm Reich, in that it assumes a major role in the personality organization. Its relationship to the "conversation of gestures" developed by Mead is, as we shall see, quite close. Let us examine some examples of Level I interpersonal communications.

How a Poignant Woman Provokes a Helpful Attitude. A patient comes to a psychiatrist for an evaluation interview. She reports a long list of symptoms—insomnia, worry, depression—and a list of unfortunate events—divorce, unsympathetic employer, etc. She cries. Whether her expressions are scored separately and summarized or judged on the over-all, we derive a clear picture of a *JK* approach—"I am weak, unhappy, unlucky, in need of your help."

Let us shift now to the psychiatrist. He is under strong pressure to express sympathetic, nurturant communications. Helpless, trustful behavior tends to *pull* assistance; that is, *JK* tends to provoke *ON* from the other one. Further, the patient-therapist situation is in essence one that lends itself easily to the "needs help–offers help" relationship. There exists a tendency for the psychiatrist to express openly (or much more likely, by implication) that he knows of a way by which the patient can be assisted. This may be communicated, not in *what* he says, but in his bearing, attitude, his very quiet competence.

What makes it more complex is the fact that the verbal expression may be quite different from the actual developing relationship. The psychiatrist may interpret the dangers of dependence and the necessity for self-help. The patient may agree. If both parties tend to overemphasize verbal symbols, there may be an illusion that a collaborative relationship exists. Actually, the "nurturant interpreter–trustful follower" situation still exists, not in what the participants are *saying*, but in what they are *doing* to each other.

How the Penitentiary Trains the Prisoner for Criminal Aggression. Many institutional or cultural situations have interpersonal implications so built into them that a flexible, collaborative relationship is impossible. In prison psychiatry, for example, as analyzed by Powelson and Bendix (8), it is virtually impossible for the doctor as well as for the patient to shake off the institution's implicit punitive contempt for the inmate. The penitentiary administration tells the prisoner, by the prison architecture, the structure of the guard-inmate relationship, and by every nonverbal cue possible that he is a dangerous, evil, untrustworthy outcast. The prisoner often responds to this interpersonal pressure by accepting the role he is being trained for. That is *BCD* pulls *EFG*. The same interpersonal connotations were typical of the descriptive preanalytic psychiatry of the last century and of incarcerative psychiatry of the present. Here we must note again that human relationships are never one-sided and that those which are rigid or of long duration tend to be selective on both sides. Thus, as Powelson has pointed out, the recidivist criminal is least anxious when he is in passive rebellion against a strong punitive authority who feeds him and beats him.

Interpersonal Implications Underlie Social Organizations. To a lesser degree any doctor-patient relationship tends to have predetermined interpersonal structure. At least at the beginning it is highly loaded by the dependence-helpfulness axis.

Unverbalized interpersonal assumptions tend to pervade every social organization. The unwitting evaluation of the differing roles of

orderly, nurse, psychotherapist, psychiatrist, and administrator in relationship to each other is an inevitable phenomenon in any psychiatric hospital. The way in which eddies from these power whirlpools reach and relate to the patient is probably more important in terms of the remission rate than the number of electric shock machines or the skill of the psychotherapists. Factory, department store, office, university—all have these complex networks of routine, unverbalized evaluation through which power, prestige, contempt, punishment, acceptance, etc., are expressed. Systematic understanding of these social hierarchies and their effect on the clients, patients, employees, customers, and students is a problem for the sociologist or the industrial psychologist. Investigations in these areas will very likely reveal that individuals tend to select jobs and occupational roles in accordance with their interpersonal techniques for anxiety reduction. We consider these phenomena here because they demonstrate the implicit and automatic nature of interpersonal reactivity.

How the Professor and Student Train Each Other To Be Professor and Student. The teacher-student relationship, obviously loaded with power implications, serves to illustrate some details of reflex communication. Professors are so addicted to the stereotyped *teaching reflex* that they often cannot inhibit the didactic response. We recall the psychology professor who had developed at some length in a lecture the thesis that teachers or psychotherapists should not give answers but should stimulate the student or the patient to seek answers himself. "Don't let them become dependent on you; make them think for themselves." As soon as the lecture was over, a graduate student (well trained to the dependency reflex) rushed up with a question: "In my undergraduate teaching section the students are continually asking me to solve their personal problems and demanding answers. What shall I do?" Pausing only to clear his throat, the professor reflexly responded: "Yes, you'll always find your students tending to trap you into solving their problems for them—the problems that they should work out for themselves. Now what I'd do if I were you is, first, I'd get them to. . . ." The verbal content of an interaction can be quite divorced from the interpersonal meaning.

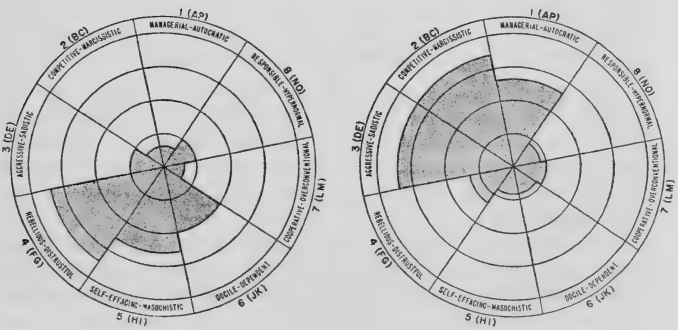
These subtle, ubiquitous, automatic role relationships have as their function the minimization of anxiety. They set up smooth-flowing reciprocal interactions of ask-teach, attack-defend, etc. On those occasions when the pattern of interpersonal reflexes breaks down or is ambiguous, considerable distress generally results—manifested in the accustomed symptoms of anxiousness. Some students are made uncomfortable by a teacher who refuses to lecture and assume the

authoritative role. Patients often manifest initial bewilderment and insecurity when the therapist appears disinterested in giving quick answers to their problems. Symbiotic marriage partnerships can be thrown into panic when the implicit assumptions of power, guilt, and dependence on which they rest are temporarily threatened.

So far we have viewed interpersonal communications as automatic responses in standard institutional situations. We shall now proceed to study them in the context of the individual personality, in terms of the classification system of 16 variables presented in the last chapter.

The preliminary data on which this system is based was obtained by giving extensive psychological test batteries to some 200 subjects and then recording their interactions in 45 discussion or therapy groups. The pretesting procedures produced many ratings of Level II (conscious perception) and Level III (symbolic productions) behavior. The Level I-R communications were obtained by studying the subjects' behavior as they interacted with the four or five other group members. Let us select one subject as an example and follow him through this procedure.

How a Sullen Patient Teaches Others to Reject Him. A thirty-year-old man came to the psychiatric clinic with complaints of depression, general immobilization, and social isolation. After intake interviews and testing, he entered a psychotherapy group along with four other patients. All the group members were strangers when they met.



SUBJECT FELLOW GROUP MEMBERS

Figure 5. Summary of Interpersonal Interactions Between an Illustrative Subject and Four Fellow Group Members.

The verbal transactions of the group were recorded and transcribed. Psychologists then rated each speech which this patient made and each verbal reaction by other patients to him. The sixteen-point circular continuum of variables (presented in the preceding chapter) was employed in these ratings. The interpersonal actions of the subject and the reactions of the fellow group members during the first eight sessions were then summarized, combined into octants, and plotted on a circular profile. These Level I-R "self" and "other" profiles are presented in Figure 5.

This diagram tells us that the subject acted in a bitter, distrustful manner (*FGH*) in a group. He complained, demanded, accused, withdrew. His fellow patients reacted to him with a critical, unsympathetic, rejecting exasperation (*CDE*). After eight sessions in the group the patient had virtually duplicated the suspicious, isolated pattern that had originally brought him to the clinic. This rather pure and didactically simple interpersonal situation serves to illustrate several interesting aspects of interpersonal theory which will now be considered.

The Interpersonal Reflex

First we ask, what did this patient do to get four strangers to agree on his social stimulus value? It seems that he trained them to react to him in a very specific way—provoking them to rejection and irritation. This question becomes more important (from the diagnostic viewpoint) when we remember that he reports that over the span of his life he has consistently tended to remain isolated and despised by others. How does he do this? He made, on the average, ten verbal comments in each group session. What happened in these eight meetings of the group to bring about a significant disaffiliation?

What Are Interpersonal Reflexes? When we trace his interpersonal actions back to the original recorded protocols we discover that a typical pattern of Level I interaction existed. The individual units of this behavior we call *interpersonal mechanisms or interpersonal reflexes.* They are defined as the observable, expressive units of face-to-face social behavior.

These reflexes are automatic and usually involuntary responses to interpersonal situations. They are often independent of the content of the communication. They are the individual's spontaneous methods of reacting to others.

The exact manner in which these Level I communications are expressed is a complex problem. This much is clear: they are expressed partly in the content or verbal meaning of the communication, but

primarily in the tone of voice, gesture, carriage, and external appearance. Although we do not know the specific method by which human beings communicate their emotional messages to each other, we can rate with reliable confidence the over-all, molar effect. Raters (trained psychologists or untrained fellow patients) can agree with impressive reliability in rating what subjects do to each other in interpersonal situations. Preliminary research by Blanche Sweet (10) suggests that listening to recordings leads to more effective ratings than reading typed transcriptions. Sound movies would provide the optimal techniques for preserving the nuances involved in interpersonal reflexes. Future research may determine the specific way in which these spontaneous interpersonal meanings manifest themselves to others. The reflex manner in which human beings react to others and train others to respond to them in selective ways is, I believe, the most important single aspect of personality. The systematic estimates of a patient's repertoire of interpersonal reflexes is a key factor in functional diagnosis. Awareness and, if possible, modification of crippled or maladaptive reflexes should be a basic step in psychotherapy. When more evidence as to the mode of expression—gesture, carriage, content of speech—is at hand, some additions to therapeutic practice may develop.

The automatic and involuntary nature of interpersonal reflexes makes them difficult to observe and measure by a participant in any interaction. They are, for the same reason, most resistant to therapeutic change. The more the members of the psychotherapy group tried to explain to the subject how and why he irritated them, the more he protested his feelings of injury. Later, intellectual insight and voluntary controlled changes to cooperative, self-confident behavior developed. These were, however, quite tentative and unnatural. During many months of treatment spontaneous reactivity brought a return of the original responses. This involves, of course, the familiar process of "working through," basic to most therapeutic enterprises.

Physiological and Interpersonal Reflexes. The on-going involuntary nature of these reflexes demands continual emphasis to keep them from slipping out of focus. This is the hidden dimension of behavior. This is the area of personality which it never occurs to us to mention, so basic that it is taken for granted. Consider this analogy: A physician conducting a medical examination interview may ask the patient to report any physiological events he may have noticed during the previous day. The patient might describe the heavy feeling in his stomach after lunch, the headache during the evening. It would not occur to the patient to recall that he automatically blinked his eyes on

the average of three times a minute, 180 times an hour, 2,880 times during the 16 hours of a waking day. Nor would the patient ordinarily be able to report the absence of a reflex. He might describe the symptom that accompanies it, but the presence or absence of physical reflexes is generally unnoticed by the patient. His failure to mention them in the medical interview is, of course, natural and proper. It is not a sign of malignant "repressive" mechanisms but rather of the implicit nature of these important behaviors.

Compare this, now, with the psychiatric interview. If asked to report the pertinent psychological events of the previous day, the patient might remember the feeling of depression in the forenoon, rage at the office, and worry over bills at home in the evening. It is inconceivable that he would or could recount that in almost every interpersonal situation he conveyed by gesture, bearing, tone of voice, and the negativism of his verbalization a consistent message of pessimism and resentment, that over 70 per cent of his interpersonal mechanisms were in the same direction, that the "others" with whom he regularly interacts have been trained to respond to him in an irritated and rejecting manner. Nor would he indicate that the interpersonal reflexes expressing tender or affiliative purposes are crippled and inhibited. Again, his failure to mention these involuntary actions is not a symptom or a pathological repressive maneuver. The reflexes which we measure at Level I tend to operate as background to the verbal content of the communication. It is the latter to which we consciously attend; but it is the former which set the tone and provide the interpersonal significance of the event.

Interpersonal reflexes are considerably more tricky to deal with than their physical analogues. The medical examiner has routine, straightforward methods for checking physiological reflexes. The psychological situation is not so simple. The therapist may have to examine his own reflexive responses to the patient with great care before he can detect the exasperated boredom or irritation that this type of patient can pull from others.

THE INTERPERSONAL REFLEX NEED NOT BE CONSCIOUS. In this chapter we are dealing with the level of interpersonal action. In the following chapter we shall define conscious description as being a different level of behavior. Level I is what the subject does. Level II is what he says he does.

The interpersonal reflex is, therefore, not necessarily a conscious expression. It can be involuntary and not a deliberate or conscious performance.

This difference has been noted by other writers. Mead (7, p. 18) points out the difference between gestural behavior (Level I) and consciousness (Level II). "The mechanism of the social act can be traced out without introducing into it the conception of consciousness as a separable element within that act; hence the social act, in its more elementary stages or forms, is possible without, or apart from, some form of consciousness." Cassirer (4, p. 53) has made the same distinction:

> Speech is not a simple and uniform phenomenon. It consists of different elements which, both biologically and systematically, are not on the same level. We must try to find the order and interrelationships of the constituent elements; we must, as it were, distinguish the various geological strata of speech. The first and most fundamental stratum is evidently the language of the emotions. A great portion of all human utterance still belongs to this stratum. But there is a form of speech that shows us quite a different type. Here the word is by no means a mere interjection; it is not an involuntary expression of feeling, but a part of a sentence which has a definite syntactical and logical structure. It is true that even in highly developed, in theoretical language the connection with the first element is not entirely broken off. Scarcely a sentence can be found—except perhaps the pure formal sentences of mathematics—without a certain affective or emotional tinge.

The thesis of the present work is in agreement with these two authors. It is possible to express interpersonal behavior of which one is not aware. This is not to say that social reflex behavior is to be equated with the classic "unconscious." We are speaking instead of an involuntary, automatic behavior of which the subject can or cannot be aware.

Previous Literature on Interpersonal Communication. In making interpersonal communication a key concept in the present theory of personality, we are by no means introducing a new planet into the constellation of personality processes. The importance of reflex interactive behavior has been long recognized by sociologists and anthropologists.

The psychologist-philosopher George H. Mead made a similar notion the keystone of his "social behaviorism." Mead has traced in great detail the development of human communication, and he discussed many concepts which are directly related to the interpersonal system developed in this book. While space does not permit the detailed analysis which Mead's work deserves, it might be useful to note some of the concepts which are directly related to Level I communications. Mead places the origin of communication in the "conversation of gestures" which, as he defines it, is very close to the definition of Level I

used in this book. "We are reading the meaning of the conduct of other people when, perhaps, they are not aware of it. There is something that reveals to us what the purpose is—just the glance of an eye, the attitude of the body which leads to the response. The communication set up in this way between individuals may be very perfect. Conversation in gestures may be carried on which cannot be translated into articulate speech." (7, p. 14) He continues in the same section to say: "But if we are going to broaden the concept of language in the sense I have spoken of, so that it takes in the underlying attitudes, we can see that the so-called intent, the idea we are talking about is one that is involved in the gesture or attitudes which we are using. The offering of a chair to a person who comes into the room is in itself a courteous act. We do not have to assume that a person says to himself that this person wants a chair. The offering of a chair by a person of good manners is something which is almost instinctive. This is the very attitude of the individual. From the point of view of the observer it is a gesture. Such early stages of social acts precede the symbol proper, and deliberate communication." (7, p. 15)

From this passage we see that the conversation of gestures (which we call reflex communication) is, for Mead, a lower order of behavior. As he develops his theory of the "significant symbol" he tends to depreciate the importance of reflex, automatic (nonconscious) communication. When he compares it with vocal, self-conscious, reflexive language,[1] this becomes quite apparent: "When, now, that gesture means this idea behind it and it arouses that idea in the other individual, then we have a significant symbol. In the case of the dog-fight (Mead's example of Level I, gestural communication), we have a gesture which calls out appropriate response; in the present case we have a symbol which answers to a meaning in the experience of the first individual and which also calls out that meaning in the second individual. Where the gesture reaches that situation it has become what we

[1] Language usage becomes tricky at this point. When Mead uses the term *reflexive*, he means something quite different from the term *reflex* as used in this book. He states: "It is by means of reflexiveness—the turning back of the experience of the individual upon himself that the whole social process is thus brought into the experience of the individuals involved in it; it is by such means, which enable the individual to take the attitude of the other toward himself, that the individual is able consciously to adjust himself to that process, and to modify the resultant of that process in any given social act in terms of his adjustment to it. Reflexiveness, then, is the essential condition, within the social process, for the development of mind." (7, p. 134) This terminology contrasts with that used in this book. The interpersonal behavior at Level I which is (or at least, can be) nonconscious, involuntary, gestural, which involves an automatic communication with or "training of" the other one we call *reflex*. The variable by which we measure Level I behavior is the interpersonal reflex, or the interpersonal mechanism.

call "language." It is now a significant symbol and it signifies a certain meaning." (7, p. 45)

Notice in this quotation how Mead distinguishes between the nonconscious language of gestures and the highly conscious significant symbol. The latter is a high-order concept and from the systematic point of view involves three separate levels of personality. Mead's purpose in developing a social theory of mind led him to employ complex combinations of personality variables. This is quite justifiable from the standpoint of Mead's conceptual intentions, but prevents a direct comparison to the systematic definition of levels which we are attempting in this book. In the broader sense, Mead's social behaviorism can rightly be considered the creative watershed to which later theories of interpersonal relations can trace their sources.

Roughly contemporaneous with Mead was another great pioneer in the field of culture and personality—Edward Sapir. Working as a linguist-anthropologist, Professor Sapir directly inspired many of the most well-known theories and investigations in the field of cultural anthropology. As early as the year 1927, Sapir was stressing the importance of interpersonal communication:

> If one is at all given to analysis, one is impressed with the extreme complexity of the various types of human behavior, and it may be assumed that the things we take for granted in our ordinary, everyday life are as strange and as unexplainable as anything we might find. Thus, one comes to think that the matter of speech is very far from being the self-evident or simple thing that we think it to be; that it is capable of a very great deal of refined analysis from the standpoint of human behavior; and that one might, in the process of making such analyses, accumulate certain ideas for the research of personality problems.
>
> There is one thing that strikes us as interesting about speech; on the one hand, we find it difficult to analyze; on the other hand, we are very much guided by it in our actual experience. That is, perhaps, something of a paradox, yet both the simple mind and the keenest of scientists know very well that we do not react to the suggestions of the environment in accordance with our specific knowledge alone. Some of us are more intuitive than others, it is true, but none is entirely lacking in the ability to gather and be guided by speech impressions in the intuitive exploration of personality. We are taught that when a man speaks he says something that he means to communicate. That, of course, is not necessarily so. He intends to say something, as a rule, yet what he actually communicates may be measurably different from what he started out to convey. We often form a judgment of what he is by what he does not say, and we may be very wise to refuse to limit the evidence for judgment to the overt content of speech. (9, pp. 892–93)

Later in the same paper Sapir summarizes: "It should be fairly clear from our hasty review that if we make a level-to-level analysis of the speech of an individual and if we carefully see each of these levels in

its social perspective, we obtain a valuable lever for psychiatric work. It is possible that the kind of analysis which has here been suggested, if carried far enough, may enable us to arrive at certain very pertinent conclusions regarding personality." (9, p. 905)

If these predictions made over a quarter of a century ago seem most in tune with current trends, it can hardly be considered accidental. Working with Sapir at the time were many theorists who have since become well-known exponents of the culture theory of personality—Sullivan, Dollard, Thomas.

The level of behavior which is operationally defined in this chapter as the Level of Public Communication possesses, therefore, a most eminent scientific heritage. Starting from Darwin and Wundt's concern with the gestural expression of emotion, taking its philosophic roots in the linguistic concepts of Sapir and Mead, and finding its psychiatric application in the writings of Fromm, Horney, Moreno, and Sullivan, the basic notion of interpersonal communication has for a century excited the interest of socially oriented theorists.

The first clinical and empirical approach to interpersonal communication was developed by J. L. Moreno. Many ingenious and creative innovations were introduced by this pioneering worker. For over twenty years Moreno has employed sociometric methods to study group structure. These techniques indicate the bonds of attraction and repulsion which exist among group members and provide an objective picture of the pattern of interpersonal relationships. Moreno's valuable contributions have not been fully exploited because of the absence of empirical studies. Moreno has not based his measurements upon a system of interpersonal variables. His sociometric methods possess considerable functional value, but they do not provide an interpersonal diagnosis in terms of a fixed system of variables.

In the last five years three comprehensive empirical systems for classifying interpersonal behavior have been described in the literature. Bales (1) has presented a reliable and effective method of categorizing interpersonal processes in terms of positive, negative, or neutral orientation toward a group goal. This has been applied mainly to group decisions and group problem-solving behavior. The English psychiatrist Bion (2) and his American follower Thelen (11) have developed a method of rating the individual's response to the group experience. This has been applied to problems of social structure in psychotherapy groups and to group-dynamics situations. The third method for measuring social interaction is the interpersonal system described in this book. The systems developed by Bales and Bion are major methodological achievements. They differ from the present interpersonal system in several respects. They are not tied to a theory

of personality nor a system of multilevel measurement. The aim of Bales and Bion is to classify behavior that is most crucial to their particular goals—group problem solving and group therapy process. The aim of the interpersonal system is to develop a method of measuring interpersonal behavior which will be coordinate with the measures of interpersonal behavior at other levels of personality and which will fit into a multilevel pattern of interpersonal diagnosis. The reflexes of Level I are, perhaps, the most crucial aspect of personality, but from the standpoint of functional diagnosis and dynamic theory design they must fit into a multilevel structure.

In selecting the variables for classifying Level I communication, we have kept in mind, therefore, not the purpose or structure or task of the group, but the structure of the individual's total personality. With this discussion as background, we shall now consider the empirical methodology developed for classifying interpersonal behavior.

Listing the Interpersonal Reflexes. To make objective measurements of the reflex phenomena of Level I, it was necessary to have a finite and defined list of interpersonal behaviors. Such a matrix has been presented in the form of the sixteen-point circular continuum. The problem becomes that of determining the various interactions which reflect the sixteen basic motivations. Because we are dealing at this level of personality with communication process—what one person *does* to another—it is convenient to use verbs (transitive verbs) as the descriptive terms. Figure 1, Chapter 6, presents the sixteen generic interpersonal themes along with a list of sample activities which illustrates the range of each point around the circle.

For each generic theme there is, of course, an inexhaustible list of verbs. The terms used here are most appropriate for verbal exchanges in therapeutic or diagnostic contexts. Thus, we suggest that *to boast, to act narcissistically, to establish autonomy and independence, to act self-confident* all contain about the same proportion of dominance-hostility as indicated by the point *B* on the circle. By this we mean that they express the same qualitative purpose of narcissistic self-approval. The fact that they differ in amount, degree, or extremity of the purpose is handled by the intensity scale. Other lists are necessary for categorizing nonverbal actions (frowns, gestures, voice tones) and preverbal situations (nursery school interactions, etc.).

To illustrate this system of scoring social behavior, two samples of interaction are here presented: a section of a modern play, and a nonverbal nursery school exchange. A detailed description and illustration of the use of several Level I measures in the psychiatric clinic will be found in Appendix 1.

THE SCORING OF INTERPERSONAL MECHANISMS AS APPLIED TO A CONVERSATION IN A MODERN PLAY. The following passage represents a conversation among three of the central characters of *Death of a Salesman* by Arthur Miller.[2] The scoring of each interpersonal reflex involves three items: the code letter representing the location of the action along the circular continuum, the verb considered most closely descriptive of the action, and the rating of intensity of the mechanism along the 4-point scale. The exchange between Biff and his mother, Linda, serves as a nice illustration of a punitive-guilty relationship.

	Interpersonal mechanism	*Descriptive verb*	*Intensity*
LINDA: You're a pair of animals! Not one, not another living soul would have had the cruelty to walk out on that man in a restaurant.	*E*	Condemn	3
BIFF, not looking at her: Is that what he said?	*J*	Inquire	1
LINDA: He didn't have to say anything. He was so humiliated he nearly limped when he came in.	*P*	Inform	1
HAPPY: But, Mom, he had a great time with us.	*L* *B*	Conciliate Resist	2 1
BIFF, cutting him off violently: Shut up.	*D*	Coerce	3
[Without another word, HAPPY goes upstairs.]	*H*	Withdraw	3
LINDA: You! You didn't even go to see if he was all right!	*F*	Complain	2
BIFF, still on the floor in front of LINDA, the flowers in his hand; with self-loathing: No, Didn't. Didn't do a damned thing. How do you like that, heh? Left him babbling in a toilet.	*H*	Condemn self	3
LINDA: You louse. You.	*E*	Condemn	3
BIFF: Now you hit it on the nose! [He gets up, throws flowers in the wastebasket.] The scum of the earth, and you're looking at him!	*H*	Condemn self	3
LINDA: Get out of here!	*D*	Coerce	3

THE SCORING OF INTERPERSONAL MECHANISMS AS APPLIED TO NONVERBAL INTERACTION IN A NURSERY SCHOOL SITUATION. The next example of the scoring of interpersonal reflexes presents qualitative descriptions of the behavior of three children in a nonverbal nursery

[2] Arthur Miller, *Death of a Salesman* (New York: Viking Press, 1949), pp. 124–125; quoted by permission of the publisher.

school situation. The reflexes are scored in the same fashion as the verbal interchanges described above.

		Interpersonal mechanism	*Descriptive verb*	*Intensity*
[Child A is playing with a drum.]				
1. Child B	Runs up and tries to pull drum away.	*C*	Takes by force	4
2. Child A	Tries to run away.	*H*	Withdraws	3
3. Child B	Trips A	*E*	Attacks	4
	and pulls drum away.	*C*	Takes by force	4
4. Child A	Stays on ground,	*H*	Withdraws	3
	sobs loudly.	*F*	Complains	3
5. Child B	Parades with drum, pounding it in exhibitionistic manner.	*B*	Exhibits superiority	3
6. Child C	Enters play area, walks to Child A.	*N*	Comforts	2
7. Child A	Cries louder and pushes Child C away defensively.	*F*	Complains	4
8. Child C	Pushes Child A back and throws dirt on him.	*E*	Attacks	3
9. Child B	Puts drum down and throws dirt on Child A.	*E*	Attacks	3

This interaction exemplifies the way in which individuals train others to reject and attack them. Notice how skillfully Child A (interactions 6, 7, and 8) pulls aggressive behavior from an initially well-intentioned sympathizer as well as from his original tormentor.

As we observe from this last nonverbal interaction, the judgment of interpersonal reflexes is quite independent of the concrete medium of their expression. The mechanism of *sympathize* is scored for a nonverbal pat on the back as well as for a solely verbal reassurance—or from a combination of both.

Five Methods for Measuring Level I Interpersonal Reflexes. In the preceding chapter it was pointed out that there are several methods for obtaining Level I public communications. To insure clarity we have established the working rule that any mention of Level I behavior must include a reference to the specific source of the data.

When minute-by-minute ratings are made by psychologists of interpersonal behavior (either observed directly or derived from recordings and transcriptions) the resulting data are assigned to *Level I-R.*

MMPI indices which reflect the interpersonal pressure generated by the patient's symptoms are coded *Level I-M.*

MMPI indices which predict future interpersonal behavior in group psychotherapy are coded *Level I-P.*

Scores from standardized situation tests which summarize the subject's reactions are coded *Level I-T.*[3]

When the subject's interpersonal role is summarized on the Interpersonal Check List by observers or fellow patients who have been interacting with him, the resulting sociometric indices are coded *Level I-S.*

The Level I-R ratings of interpersonal reflexes are the basic measures considered in the theoretical discussions of this chapter. In routine clinical practice, however, we have found it necessary to rely on two sets of MMPI indices of Level I behavior. *The Level I diagnosis discussed in the clinical chapters of this book is based on MMPI measures of symptomatic behavior* (*Level I-M*). The predictions of behavior in group psychotherapy, derived from the MMPI, are labeled Level I-P.

The reasons for employing these MMPI indices will now be discussed.

Level I-M Estimates of Symptomatic Behavior. Level I-R or Level I-S measurements are obtained from ratings of the subject's behavior by others who have been interacting with him or observing his interactions. It is, by definition, necessary that the subject be involved in social relationships in order to make the Level I-R and Level I-S judgments. The ideal source of these ratings is the group therapy situation where the subject's impact on several others can be determined.

This poses a practical problem, however. The functional system of personality, which we are presenting in this book, is anchored to Level I-R and Level I-S. Since this is the "action level," we consider it to be the level of greatest immediate importance. In accomplishing interpersonal diagnosis[4] at the time of intake into the psychiatric clinic, Level I-R and I-S ratings are generally not available. There has usually been no opportunity to observe the patient in extended interactions. In the Kaiser Foundation Clinic, the tests are generally administered after one intake interview with a clinician. For many

[3] The use of a *situation test* will not be illustrated in this chapter. The Kaiser Foundation project is now engaged in developing a standardized set of items for such a test. The test is being developed as a multiple-choice instrument and the patient's responses will be summarized and plotted in the same way as the other interpersonal scores.

[4] The system of interpersonal diagnosis is described in Chapter 12 of this book. Functional diagnosis is based on the multilevel interpersonal diagnosis and upon the diagnosis of variability (i.e., interlevel conflict). The use of the functional system of personality in accomplishing clinical diagnosis and prognosis is described in Chapters 15 through 22.

reasons it is impossible to get reliable Level I-R and I-S ratings from intake workers after one hour of interviewing. Thus, at the time the functional diagnostic system is called upon to make its predictions, it is forced to operate without its most important level of personality—the level of public communication.

The ideal solution to this problem would be to develop methods for obtaining reliable estimates of Level I-S and I-R from the patient's interpersonal behavior at the time of intake interview and testing. Several factors—systematic and administrative—have made this procedure infeasible. The problem of including estimates of the patient's purposive interpersonal impact at the time of intake diagnosis, as expressed through his symptoms, has been met by developing psychometric indices.

Every psychological symptom seems to have an interpersonal meaning, i.e., implications as to what the patient is communicating through the symptom, and what the patient expects to be done about it, etc. Symptoms are usually the overt reason for the patient coming to the clinic; they express an interpersonal message.

In order to measure the symptomatic impact of the patient upon the clinician, we have combined eight MMPI scales into indices which can be plotted on the circular diagnostic grid. The Level I diagnoses employed in the research studies described in this book are based on these symptomatic indices. These measures are coded Level I-M. The MMPI formulas used to derive these indices are: vertical (dominance-submission) index = Ma + Hs − D − Pt; the horizontal (love-hate) index = Hy + K − F − Sc. These MMPI scale abbreviations and the methodology for measuring Level I-M are described in Appendix 1.

These indices have considerable functional value for two reasons. First, they indicate the interpersonal reflexes employed by the patient in approaching the clinic (as indicated by his motivation and the symptomatic pressure he exerts). In the clinical situation where a decision as to treatment and prognosis is the main functional issue, the interpersonal messages picked up by the MMPI predictive indices are exactly what the diagnostician must sense. The second value of these indices is that they are based on routine test procedures which are given at the time of intake evaluation. They provide necessary estimates of Level I-S behavior which would otherwise be lacking. They plug up a most crucial gap in the multilevel diagnostic pattern.

The formulas for converting MMPI profiles into interpersonal measures are presented in Appendix 1. The norms for converting the Level I-M dominance and love indices into standard scores are presented in Appendix 5.

Level I-P Indices for Predicting Interpersonal Behavior in Group Psychotherapy. In selecting patients for therapy groups and in planning the course of individual therapy, it is obviously helpful to have a foreknowledge of the expected interpersonal behavior. The Level I-M indices predict fairly well future behavior in group therapy. We have run several studies in which Level I-M ratings were correlated with sociometric ratings of Level I-S. These results are contained in another publication. (6)

There were many cases, however, in which the Level I-M did not predict actual behavior in the group. The inaccurate forecasts were due to the fact that the group situation can pull responses from the patient that are different from his symptomatic behavior. A patient who is depressed and puts dependent pressure on the intake interviewer may become overconventional or helpful in his reactions to the future therapy group members. A different sublevel seems to be involved. The symptomatic indices seem to predict individual therapy (i.e., face-to-face reactions with a therapist) better than group therapy. This means that we can take an MMPI profile and calculate the Level I-M scores and forecast what the patient is going to do to the intake worker in planning treatment or to a future individual therapist. These MMPI cues work less well in forecasting what the patient will do to other patients in a group.

For this reason a set of indices was devised which specifically predicts behavior in group therapy. Two special MMPI scales for predicting dominant or hostile roles were developed. These are labeled Level I-P.

These scales were based on item analyses which studied the relationship of Each MMPI item to Level I Sociometric indices of group patients. The MMPI indices which predict the patient's role in group therapy make it possible to plot on the diagnostic grid the patient's Level I-M score. This predictive index is useful in assigning patients to therapy groups. This is done as follows: We derive the Level I-P indices for all patients on the group-therapy waiting list and plot them on the same diagnostic grid. It is then possible to tell at a glance the range of role behaviors to be expected. The attempt is made to keep groups heterogeneous in respect to roles. That is, we do not want any group overloaded with one interpersonal type. Experience has demonstrated that a group comprised of hysterics will tend to manifest the same interpersonal reflexes, and interaction among patients is minimized. Similarly, a group with several passively resistant personalities will tend to bog down into silence and mutual distrust.

Selection of group patients is somewhat like the casting of parts in a play. We encourage lively interchanges among group members in

which different role interactions develop. Predictive indices from MMPI scales which forecast expected behavior are the basis for assigning patients to groups. They also assist the therapist by alerting him to the pressures which will develop.

The use of MMPI predictive indices is illustrated in Appendix 1 and in Chapter 26.

Routine Reflex Patterns. During any one day the average adult runs into a wide range of interpersonal stimuli. We are challenged, pleased, bossed, obeyed, helped, and ignored on an average of several times a day. Thus, the person whose entire range of interpersonal reflexes is functioning flexibly can be expected to demonstrate appropriately each of the sixteen interpersonal reflexes many times in any day.

There are, however, many who do not react with consistent appropriateness or flexibility. One might respond to the pleasant as well as the rude stranger with a disapproving frown. Another might smile in a friendly fashion. If we study an extended sample of a subject's interactions, an interesting fact develops. Each person shows a consistent preference for certain interpersonal reflexes. Other reflexes are very difficult to elicit or absent entirely. It is possible to predict in probability terms the preferred reflexes for most individuals in a specific situation. A small percentage of individuals exist who get "others" to react to them in the widest range of possible behaviors and who can utilize a wide range of appropriate reactions. Most individuals tend to train "others" to react to them within a narrowed range of behaviors, and in turn show a restricted set of favored reflexes. Some persons show a very limited repertoire of two or three reflexes and reciprocally receive an increasingly narrow set of responses from others.

Definition of Interpersonal Role. Most everyone manifests certain automatic role patterns which he automatically assumes in the presence of each significant "other" in his life. These roles are probability tendencies to express certain interpersonal purposes with significantly higher frequency. The individual may be quite unaware of these spontaneous tendencies—to complain to his wife, to be stern with his children, to boss his secretary, to depend on the office manager. It must be remembered that we are talking here in statistical probability terms. The subject may have thousands of interactive exchanges each day with each of his significant "others," and these may range all over the interpersonal continuum. When we obtain evidence that he consistently and routinely tends to favor certain mechanisms with one individual significantly more than chance and tends to

pull certain responses from the other to a similar degree, then a role relationship exists.

This selective process of employing a narrowed range of reflexes with certain "others" works, as we have seen, in a double reinforcing manner. Most durable relationships tend to be symbiotic. Masochistic women tend to marry sadistic men; and the latter tend to marry women who tend to provoke hostility. Dependent men tend to seek nurturant superiors, who in turn are most secure when they have docile subordinates to protect.

The institutional role relationships, boss-secretary, prisoner-guard, student-teacher, etc., tend to be more stereotyped and fixed. Even so, there exists some room for role variability. Some secretaries "mother," nag, or even boss their nominal superiors. In general, however, we can surmise that personality factors enter into the choice of occupation. Those people who are least anxious and most secure when they are submitting to and depending on strong authority tend to seek and hold subordinate jobs. The network of relationships even in the simplest office setup can be bewildering in its multilevel complexity. Even so, the institutional hierarchy patterns are less involved than the familial relationships.

How a Pessimistic Man Reproaches His Wife. We cite here the very oversimplified example of the man who tends to complain to his wife. By this we mean that he reacts to his wife with the reflex of grumbling reproach (*FG*) with increased frequency, often to an inappropriate extreme. His voice may take on a tired, whiny quality the minute he enters the house. He can be, and often is, jolly, firm, or protective with his spouse. But as we pile up the thousands of interaction ratings the trend towards mild complaint becomes increasingly clear.

Now we call these reactions *reflexes* because they are not deliberate or planned. He does not deliberately decide to inject the hurt, tired note in his voice. He does not plan the slight droop of the shoulders. He may not be aware of the continuous mild passive irritation.

He may not even know the basic or broader reason for his bitterness. It might take some weeks of therapeutic exploration for him to verbalize his private feelings: (1) that he is a defeated genius whose failure was caused by his wife, (2) that he could be a success today if *she* had not persuaded him to marry and leave engineering school, (3) that he might be a rich man today if *she* had not persuaded him to give up that offer in Texas, etc. More intensive analysis would, of course, allow the roots of these feelings to be traced back even further in the patient's history.

Now this has been the oversimplified sketch of the interpersonal reflex repertoire of an essentially normal man and an essentially normal marriage. He is within normal limits because he maintains a reasonably flexible range of interpersonal behavior. He probably can employ the entire continuum of reflexes when appropriate, and without anxiety. If we could sum up all his interactions with all others over a period of time, we would see that all sixteen reflexes have been elicited, but that he tends to favor or overemphasize the mechanisms of passive complaint and distrustful, realistic hesitancy. He can lead, he can express independence, he can support others, but he tends to a moderate but significant degree to favor a grumpy bitterness in his dealing with others.

How He Provokes Superior Scorn from Four Strangers. This man entered a pilot study therapy group along with four other strangers. After eight sessions, a summary was made of his interpersonal behavior toward the other four group members. The same pattern was revealed. At times he lectured, argued, helped, cooperated, but the mechanisms which he spontaneously favored and manifested a significant majority of the time were those of passive resistance. At the same time, a summary was made of the interactions this man pulled from the others in the group, i.e., what they did to him. Again a fairly flexible pattern resulted. They listened to him with respect, they deferred to him, accepted his help, but the most frequent purposive behavior directed toward him was a mildly critical superiority (*BCD*). They liked him, respected him, but on the whole felt moderate patronizing scorn in reaction to his grumbling approach.

Notice that in seven sessions of brief interaction this subject (like the sample case described earlier) succeeded in duplicating his life situation with the four strangers in the group. This man, it must be remembered, is essentially normal. He can react flexibly and appropriately to most interpersonal situations. He has his favored interpersonal techniques for handling anxiety, as we all do, and this mild imbalance in the direction of grumpy pessimism gives him uniqueness and identity as a human being. His wife and his friends, very likely, understand and adapt to his gloomy realism with humorous (and sometimes irritable) impatience.

A Masterful Defense of Sullen Distrust. A different picture develops when we turn to the maladjustive patterns. The suspicious, isolated, immobilized case described earlier in this chapter had an extremely limited repertoire of social responses. He reacted in almost every situation with resentful distrust—to the group members, to his parents, to his acquaintances. It was next to impossible to elicit a sym-

pathetic or nurturant response from this patient. These interpersonal reflexes were completely inhibited. The expressive behavior of this man was saturated with sullen, wary, growling distrust. By consistently exhibiting this narrow range of behavior in situations when they may or may not have been appropriate, he had *trained the group members* in the same manner that he had trained all the others in his life to condemn and isolate him. This patient's reflexive techniques for provoking rejection were so well developed that the most well-intentioned, friendly approach made no dent in his armor. However sympathetic the "other one" might be, his masterful, consistent sullenness would stimulate eventual impatience. This inevitable, exasperated rejection, of course, increased his aggravation and would tend to increase the probability of further isolation. This reciprocal process by which human beings tend to pull from others responses that tend to maintain their limited security operations will be discussed under the headings of "The Principle of Self-Determination" and "The Principle of Reciprocal Interpersonal Relations." Before treating these issues, we shall pause to consider some of the methodological implications of the reflex behavior of Level I.

It will be recalled that the Level I measure is always in terms of a rating of the subject's interpersonal behavior by someone else. The subject must be involved in a social situation. The Level I judgments are then made by the observers—psychologists or fellow participants in the interaction.

Patients as Diagnostic Instruments. Our measuring instrument is, therefore, another human being. Since interpersonal behavior is a functionally important dimension of personality, it is quite natural that we measure it directly—in terms of the actual social impact that the subject has on others. Some interesting implications develop. By allowing the patient to react with others—say in a group therapy situation—we make it possible for him to demonstrate, directly and openly, his repertoire of interpersonal reflexes. He tends to recreate to a mild extent in the group his neurotic adjustment. He accomplishes his own interpersonal diagnosis.

The therapeutic group, thus, serves as a small subsociety, a miniature world. The members of a therapy group have a valuable diagnostic function. When we ask them to rate each other's interpersonal behavior (on a check list or sociometric blank, covering the range of the sixteen generic variables) we obtain an estimate of what each patient has done to the others.

Why Patients Produce Better Interpersonal Diagnoses than Psychologists. Patients tend to rate each other much in the same

way as trained psychologists. Sometimes the members of a therapy group see a fellow patient differently from the therapist. When these discrepancies in Level I ratings occur, it is usually the psychiatrist or psychologist whose judgments are less accurate and less valuable. Clinicians' judgments of patients tend to be complicated affairs. They are often very derived, distorted by theoretical or "depth" considerations. Naïve, untrained subjects—fellow patients, family members—generally judge each other in terms of their direct reactions to the subject. They tend to like, fear, respect each other, and their ratings reflect these reactions. They do not "psychologize." The ratings of trained professional workers tend to be much more intellectual. It is not good form for them to admit that they like, fear, or look up to a patient. Their ratings, indeed, are classically supposed to be divorced from these personal reactions.

We have found, therefore, that psychologists and psychiatrists tend to give interesting and theoretically valid ratings of deeper motives and future developments. Since patients spend most of their time interacting with nontrained, psychologically naive individuals, it is from the latter that we obtain the best diagnosis of their "main street" stimulus value. The meaning of such a rating is not clear-cut. Many extraneous factors influence it—the personality of the rater and the climate of the therapy group, to name two. Some of these complications can be handled by standardizing procedures and corrections for perceptual distortion on the part of the rater. Others cannot be controlled. Even so, the rating from the nonprofessional is much more straightforward an estimate of Level I communication.

Professional Clinicians as Measuring Instruments. There are very good reasons why trained clinicians are less effective and reliable when asked to rate single-level variables. The factors that make them good clinicians tend to hamper their becoming good rating instruments. The key to clinical skill is the ability to make multilevel observations and to synthesize them. The good psychiatrist is trained to perceive many cues from many levels at one time and to act upon these cues effectively.

He is able to predict what the multilevel behavior of the patient will be in the long-range future, and also in the immediate future. Thus he develops the intuitive expectation as to the patient's reaction to an interpretative intervention on his part. He is able to grasp what the patient may be communicating at several levels as he free-associates. He attends, now to the verbal content, now to the symbolic cues (slips of the tongue, etc.), now to the immediate interpersonal pressure from the patient. His behavior in response to the

patient's activity is usually based on a complex integration of these many cues. In many cases he does not stop to sort out all these cues into categories. He may be hard put to explain exactly what it was in the pattern of the patient's communication that led him to his conclusion.

Now this is a most frustrating situation to the scientist who seeks to measure factors involved in therapeutic communication or diagnosis. Scientific ratings are supposed to be reliable, repeatable, explicit, specific. At this primitive stage of the science they are inevitably single-level measurements. Often the scientist is very discouraged when he attempts to pin the clinician down. He knows that the clinician responds to cues with considerable skill. But his rating scales fail miserably to tap the richness of the clinical experience. The practitioner is likewise frustrated and sometimes irritated by what he calls the "simple-minded" quantitative approach of the scientist.

The Kaiser Foundation project has worked out a tentative solution to this dilemma by avoiding the use of clinicians as rating instruments. The clinician's insights are employed in setting up the system, in determining the rating categories. Thus we have long discussions with psychiatrists and practitioners before deciding how many levels to employ in the system. Clinicians tell us what kind of conflicts, identification patterns, and therapeutic phenomena they run into. They produce many multilevel hypotheses about personality dynamics, the nature of change in therapy, and so on. The system is then expanded and revised to get at these phenomena. New experimental uses for the system are suggested. A clinician may report that certain patients show a particular imagery of "Father." The system is then broadened to get at this dimension—we may add a new rating category to the TAT analysis which picks up "symbolic view of Father." Clinical intuition is thus mainly responsible for what kind of a system and what kind of measurements are made.

But we attempt to keep the clinician far away from the actual measurement process. He tells us what to measure; but we do not ask him to measure it for us. At the present time the project's measurement procedures (both research and diagnostic) are executed completely by nonprofessional workers. The tests are administered by trained technicians. The specific ratings are done by the patient about himself, by his fellow patient, or by technicians carefully trained to make unilevel judgments. The TAT stories are not employed as global productions upon which multilevel analyses of the patient's personality can be based. They are defined as Level III data. A crew of intelligent, but nonpsychologically trained technicians then moves in to rate the TAT stories for the interpersonal themes. These technicians are

not encumbered with the complex clinical skills or broad theoretical conceptions. Their job is to do unilevel ratings, which they accomplish with straightforward competence.

The standard interpersonal system test battery includes seven different tests. These are administered, scored, rated, and profiled by nonprofessional or semiprofessional help. In essence, the hundreds of molecular scores are fed into the system and the resulting matrix of multidimensional scores is handed to the clinician who then interprets it. The clinician applies his creative, intuitive skills to understand the complex patterns of scores and to relate this to the facts that he has about the patient from the interview. He makes sense out of a pattern of scores—a task which neither the unsophisticated patient nor the psychologically untrained technician can hope to perform. The professional energy is thus applied to developing the machinery of the system and to the final product which comes from this machinery. The running of the machine and the processing of the measurements (including ratings of symbolism) are accomplished by specially trained technicians.

There is one occasion upon which we ask clinicians to make ratings. This is done when we want to study the clinicians and not the patients. If we ask twenty clinical workers to rate a group of patients or a set of test scores on the variable *repression* or *ego strength*, the results tell us how the individual clinician or how the entire group of clinicians conceive of these two variables. In two research explorations done by the research group it was determined that the clinical psychologists who rated repression and ego strength relied mainly on Level II cues. Patients who claimed to be strong, friendly, and healthy were rated as repressers and having strong egos. The results of the ratings thus told us how these psychologists conceived of the variables and did not necessarily measure the variables in an independently valid manner.

When we ask untrained people for unilevel ratings, we have a fair idea of the meaning of the data. When we ask clinicians to make unilevel ratings, we are misusing their complex skills, confusing the meaning of the system, and in most cases lowering reliability.

The Principle of Self-Determination

In the preceding pages as the illustrative case material has unfolded, I have consistently employed a rather cumbersome circumlocution to describe the interaction between the sample subject and the "others" with whom they interact. Most statements describing what "others" did to the sample case were worded so as to give responsibility to the subject. Thus we say, "He trained or provoked the group members to reject him," rather than "They rejected him." In the listing of il-

lustrative interpersonal reflexes (Figure 1), it may have been noted that both active and passive phrases were used. Thus for the interpersonal reflex *G* we have included *acts rejected* and *provokes rejection.* We take the subject as the focus of attention and as the locus of responsibility.

I have tried to stress the surprising ease and facility with which human beings can get others to respond in a uniform and repetitive way. Interpersonal reflexes operate with involuntary routine and amazing power and speed. Many subjects with maladaptive interpersonal patterns can provoke the expected response from a complete stranger in a matter of minutes. The defiant chip-on-the-shoulder; docile, fawning passivity; timid, anxious withdrawal—these are some of the interpersonal techniques which can pull the reciprocal reaction from the "other one" with unfailing regularity. Severe neurotics—defined at this level as individuals with limited ranges of reflexes—are incredibly and creatively skilled in drawing rejection, nurturance, etc., from the people with whom they deal. In many cases the "sicker" the patient, the more likely he is to have abandoned all interpersonal techniques except one—which he can handle with magnificent finesse. Most clinicians who have dealt with the disorder will be glad to testify that the so-called catatonic negation is a powerful interpersonal maneuver.

Assigning the causative factor in interpersonal relations to the subject is a standard procedure in dynamic psychiatry. The skillful therapist is usually not inclined to join the abused, unhappy, masochistic patient in lamentation. He is much more inclined to ask himself and eventually the patient, "What do you do to people with consistent and consummate skill to get them to beat you up?" The principle involved here holds that interpersonal events just do not happen to human beings by accident or external design. The active and executive role is given to the subject.

This principle (as is the case with most other psychological concepts) has been described and given more eloquent expression by novelists. Here, for example, is D. H. Lawrence outlining the notion of self-determinism: "No man . . . cuts another man's throat unless he wants to cut it, and unless the other man wants it cut. This is a complete truth. It takes two people to make a murder: a murderer and a murderee. And a murderee is a man who is murderable. And who is murderable is a man who in a profound if hidden lust desires to be murdered." (5, p. 36)

Human Beings Resist Taking Responsibility for Their Situations. This point of view plows headlong into the most widespread

resistance. It threatens the most cherished beliefs of Western philosophy—from Sophocles (who stresses fate) to the modern mental hygienists (who overemphasize parental behavior). What is more important, it threatens the most cherished illusions of the average man who bases his security and self-esteem on the traditional procedure of externalizing blame.

What we are saying here to the human being is, "You are mainly responsible for your life situation. You have created your own world. Your own interpersonal behavior has, more than any other factor, determined the reception you get from others. Your slowly developing pattern of reflexes has trained others and yourself to accept you as this sort of person—to be treated in this sort of way. You are the manager of your own destiny."

This attribution of responsibility to the subject we have called the Principle of Self-Determination. Although it has the deceptive appearance of simplicity, it is, on the contrary, the most complex kind of concept. To this notion of self-determination the average person is willing to give halfhearted and halfway approval. It is easy to see where the successful person can be self-made. He chooses his goals, works for them, and makes the grade. It is accepted quite naturally that men strive and bargain for the interpersonal goals reflected in one half of the spectrum—independence, power, popularity, affection (i.e., *B, A, P, O, N, M*). It is often less comprehensible that men should actively seek the interpersonal states represented by the other half of the circular continuum—dependence, weakness, distrust, and self-effacing modesty (*E, F, G, H, I, J*). People, it is held, just don't seek to defeat themselves.

How Three Human Beings Got What They Bargained for. A patient poignantly reports: "What I want more than anything else is to marry a dependent, feminine girl, but my three ex-wives were bossy, exploitive tyrants." This man may at the level of conscious awareness "want" a feminine girl, but his Level I behavior—immobilized, distrustful, and masochistic—is enough to force the most neutral woman into exasperated activity.

Another patient states: "What I want in a husband is a strong, successful man who will take care of me; but all I seem to attract are penniless artists and passive, dreamy bookworms." This woman may, at Level II, consciously wish for a strong husband; but her mothering, responsible Level I reflexes are so automatic and deeply ingrained that the strongest man would feel smothered and alienated by the maternal stability, to which dependent men are drawn with moth-like fascination.

A third patient says: "I want more than anything else to finish my college training and get established in a profession, but all the professors I have studied with are narrow-minded men who reject my ideas and end up by flunking me." This man may wittingly desire the prestige of professorial responsibility, but his rebellious, defiant reflexes eventually exasperate and frustrate even the most sympathetic mentor. What human beings consciously wish is often quite at variance with the results that their reflex patterns automatically create for them. For these people the sad paradox remains that voluntary intentions, verbal resolutions, and even intellectual insight are operationally feeble and numerically infinitesimal compared to the ongoing 24-hour-a-day activity of the involuntary interpersonal reactions. The frustrated student just mentioned may in a burst of intellectual awareness decide to conform to the academic demands and return to college. This resolution is a conscious, voluntary effort—very much like practicing for an hour to prevent the eye-wink reflex from operating when an object is waved in front of it. Such conscious control cannot be maintained 24 hours a day or he would be able to concentrate on nothing but the eyelid reflex. Analogously, our rebellious student faces the difficult task of fighting a continuous, exhausting battle against his spontaneous tendencies (1) to sneer and balk at authorities, thus (2) pulling from them an eventual impatient rejection, which (3) increases his tendency to sneer and balk.

Why Human Beings Develop the Reflexes of Weakness and Rejection. A second logical objection to the concept of interpersonal reflex looms up here. The eye-wink reflex, it might be argued, is naturally acquired, universal to all men, and survivally favorable. The patterns of social reactivity cited here meet none of these criteria. What is the rationale which explains how different human beings develop different rigid, self-defeating techniques of adjustment?

The first point to note is that we are concentrating here—for the sake of illustration—on maladaptive phenomena. The description of these extreme reflexes gone wild implies that other reflexes are, in contrast, inhibited. The masochistic man could not maintain a minimum of independent assertiveness; the maternal role prevented the responsible woman from manifesting the reflexes of docility and trust; the rebel possessed conformity and affiliation reflexes which were quiescent or extinct.

In the adjusted, well-functioning individual, the entire repertoire of interpersonal reflexes is operating spontaneously, flexibly, and appropriately—and when the survival situation demands aggression, he can aggress; when it calls for tenderness, he can be tender. Human

societies, however, tend not to be too well balanced. They tend to put a premium on certain interpersonal responses—competitiveness or slavish submission, for example. To survive and flourish, human beings must tailor their responses to the demands of such imbalanced cultures. Even in the most heterogenous and tolerant society the developing personality interacts with so many inflexible pressures (e.g., parent's personalities, subcultural demands) that a hierarchy of preferred reflexes develops. To say that human personality is varied and different is to say—at this level—that most everyone tends to overemphasize certain automatic interpersonal responses and to underemphasize others.

The questions still remain: Why do human beings limit their machinery of social adjustment, manifest narrowed spectra of reaction, and provoke a restricted set of reactions from others? Why do some individuals have no ability for realistic, modest self-criticism (*H*) and compulsively express only narcissistic self-enhancing mechanisms (*B*)? Why do others cling to retiring modesty and eschew the responses of proud self-confidence? Most puzzling of all (to the occidental mind): Why do some of our neighbors masochistically court interpersonal humiliation—doggedly provoking rejection and isolation from others?

For the answers to these questions we return again to Sullivan. He defines personality as the pattern of interpersonal responses employed to reduce anxiety, ward off disapproval, and maintain self-esteem. As the individual develops, he discovers that certain interpersonal responses bring danger; some bring a narrow, uncomfortable, but certain security. To use others would involve broad, attractive, but conflictful uncertainty. The more anxiety-provoking the individual's world—particularly his parental home—the more likely he is to select the familiar, narrow, certain, lesser anxiety and to avoid the promising but uncertain potentialities. The basic meanings behind any personality pattern are difficult to evaluate. The complex behavior of counterpoised motives at different levels creates the appearance of a terribly anarchic system. It is clear, however, that for many people self-esteem and security involve surprising maneuvers—including extreme self-punishment (at Level I). The "search for suffering" (*H*) can have an inexhaustible number of meanings—all functions of the multilevel integration of personality. Getting her husband to beat and exploit her can allow the masochist externalization of guilt, propitiation of guilt, passive expression of hostility, and the intense pleasures of narcissistic martyred self-pity. "No one suffers more than me; watch and I can prove it." The projection of blame for failure on others, of course, requires more and more demonstration of failure in order to maintain the allegation. In addition, by selecting this set of

aggression-provoking responses, the masochist avoids the potentially conflict-laden area of active hostility (*DE*), marital collaboration and sexual partnership (*LM*), and assertive responsibility (*BAP*). Most severe martyrs, of course, express indirectly the purposive behaviors that they inhibit at the public level. They accomplish their private aims—aggressive, narcissistic, exploitive, and, very likely, sexual—by the indirect, cumbersome, and unsatisfactory method of acting hurt and provoking aggression from others.

The Pressure to Repeat Responses. Interpersonal activities are designed to avoid the greater anxiety. It might be said in general that the human being experiences less anxiety in a familiar situation than in a strange one, and less anxiety when he is employing familiar responses than strange ones. Reciprocal relationships with crucial "others" develop quite naturally here. The more an individual restricts his actions to one narrow sector of the interpersonal spectrum, the more he restricts the social environment he faces. That is, the man who continually employs submissive reflexes tends to train people to boss him and discourage people from looking to him for forceful leadership. This tendency to repeat the patterns of the past is similar to the principal of least action which is described by Whitehead (12, p. 108) as that phenomenon in which "cases will group round the individual perception as envisaging (without self-consciousness) that one immediate possibility of attainment which represents the closest analogy to its own immediate past." The interpersonal world of the submissive man tends to become quite lopsided, putting more and more pressure on him to obey and not to command.

Survival anxiety presses the individual to repeat and narrow down his adjustive responses. He thus comes to a stable but restricted reciprocal relationship with his interpersonal world. But this is only one half of the total event.

The Pressure to Change Responses. In addition to this tendency for the familiar personal environment to become limited in scope, we have seen that the environment at large presents one with a wide range of social stimuli. In any single day most individuals roaming around in their ecological space find suitable situations for expressing all sixteen interpersonal mechanisms. To the extent that the individual inhibits some of these, he is not employing the appropriate responses demanded by the environment. Failure to adapt to the world about it generally creates survival anxiety in the organism.

The Insoluble Dilemma of Adjustment: Stability Versus Flexibility. The human being is, according to this view, caught be-

tween two polar whirlpools of anxiety. Rigid repetition of interpersonal responses minimizes conflict and provides the security of continuity and sameness—in Whitehead's useful terminology called "endurance." But the environment at large is not the same—and adjustment to it demands a flexible generality of interpersonal response. The notational system and general premises of the present work lead us to conclude that this is the critical survival dilemma—the basic conflict, if you please, of human nature. A quotation from Egon Brunswik (3) appears pertinent here. He points out that "survival and its sub-units, which may be defined as the establishment of *stable* interrelationships with the environment, are possible only if the organism is able to establish compensatory balance in the face of comparative chaos within the physical environment. Ambiguity of [stimulus] cues and means [i.e., organismic responses] relative to the vitally relevant objects and results must find its counterpart in an *ambiguity* and *flexibility* of the . . . mediating processes in the organism." [5] Or, to use Whitehead's words, ". . . every scheme for the analysis of nature has to face these two facts *change* and *endurance*." The momentum of the logic we are using in this book has led us to define two basic maladjustive factors in terms of these dichotomous sources of anxiety: rigidity, which brings a narrow adjustment to one aspect of the environment, and unstable oscillation which is an intense attempt to adjust to all aspects of the presented environment. These concepts involve the multilevel organization and diagnosis of personality and must await publication in a subsequent volume.

Between the two maladjustive extremes of personality, rigid continuity and oscillating noncontinuity, occur the greatest majority of human adjustments. Most individuals, as we have seen, tend to select a limited set of preferred reflexes which operate spontaneously, but not with inflexible repetition. The average individual is still able to call out automatically any and all reflexes along the continuum to meet the exigencies of the environment. In general orientation and in the crucial decisions of his life, he is likely, however, to have employed the narrowed responses. And he has very likely succeeded in training the significant "others" in his life to react in reciprocity to his interpersonal style. The average person has thus created himself and his world along the lines of a purposive but limited set of interpersonal relationships. He has worked out, usually by means of involuntary reflexes, a *balance* which is best calculated to meet the double threats of rigidity and chaotic flexibility. His Level I automatic communications have provided him with smoothly operating techniques de-

[5] The italics and parenthetic notes are the author's.

termining the nature of his self and world. Like his more neurotic brethren, he too gets from life the interpersonal returns for which he has bargained—just that and no more.

The Principle of Reciprocal Interpersonal Relations

The principle of self-determination as it operates at Level I has several implications. The notion that we must take the credit or blame for our own life situations has had an obvious effect on clinical practice. It assigns to the individual patient the responsibility for developing and managing his own personality. This is a terrible power that we assign to him, one which he is often not willing to believe or accept. The key factors in personality seem to be the purposive messages we express to others in our Level I communications. For many patients these are signals of weakness and blame: "Others must help me" and "Others are my undoing" are familiar and poignant themes expressed by many psychiatric patients. The notion of self-determination removes the protective devices of projection and externalization—giving in return a priceless, but often unwelcome gift of personal power.

In developing these themes a rather curious imbalance may have been noted. For purposes of exposition we have concentrated on the viewpoint of the subject. At times it may have implied a paradoxical situation in which everyone goes around training others to respond to him in specified ways. This is, of course, rather puzzling. If everyone is actively creating his own interpersonal world, this leaves no one left to be passively trained by others.

This dilemma is caused by the concentration on one side of the interpersonal exchange—the subject. Actually, we know that we can never understand interpersonal relationships unless we study both sides of the interaction. When we pause to isolate and study one side—the self or subject side—of interpersonal behavior, we do so at the risk of distortion. As we consider, in turn, the various levels and areas, we encounter the danger of segmental overemphasis—one of the plagues of psychological theory. The principle of self-determination is a probability statement which has reference to the global organization of personality in general and Level I in particular. The over-all system of the total personality is for all predictive purposes the unit upon which we focus. It has special importance in shaping a strategy and tactic of psychotherapy. It should be kept clear that in the preceding section we have, for expository purposes, stressed the "self" response and understressed the "other," or environmental factors. In actuality both partners in any relationship share the responsibility for its development—a mutual determining operation is occurring. The mother does not create the child's personality. The child does not create the

maternal reaction. They both are engaged in a most intricate reciprocal process to which both bring determinative motivations.

MANY INTERPERSONAL EXCHANGES REINFORCE THE ORIGINAL REFLEX. The time has now come to consider both sides of the interpersonal situation—the two-person commerce of communication. The first point worth comment is the reinforcing quality of social interaction. Our actions toward other people generally have the effect of pulling a reciprocal response from them. This in turn tends to strengthen our original action. If you walk up and aggressively shove a stranger, the chances are good that he will shove you back. Of course, this rule does not work uniformly. One out of a hundred might be that Christian soul who would tenderly embrace you. A few might slink away from you. A few might docilely attempt to placate you. The largest percentage would mirror your aggression—and probably shove back. Your counterresponse then becomes the issue. You might apologize, you might retreat, but assuming you are an "aggressive shover" to begin with, the statistically probable response is to shove back, perhaps harder.

You have provoked a response which has reinforced your original action. This reinforcing process has been dignified with the title of the principle of reciprocal interpersonal relations. This is a general probability principle. It holds that: *Interpersonal reflexes tend (with a probability significantly greater than chance) to initiate or invite reciprocal interpersonal responses from the "other" person in the interaction that lead to a repetition of the original reflex.*

Before considering the ramifications and qualifications of this principle we shall glance at a few examples of its operation.

HOW GROUP THERAPY PATIENTS PROVOKE EACH OTHER TO INCREASING REPETITION. Group psychotherapy provides a splendid opportunity to observe the development of interpersonal patterns. The members come together as strangers. The initial sessions are anxiety-provoking. The novelty and tension combine to produce interpersonal reflex behavior which is quite clear-cut. Unless a definite selection principle is employed, the members of a group tend to scatter around the interpersonal circle. That is, one or two will demonstrate helpless, dependent reflexes. One or two will be sullen and silent. One or two will be superior, mildly antagonistic. One or two will briskly begin to take leadership roles, try to "get the ball rolling," help the other patients, etc. The pattern of reciprocal reflexes that develops is rich and complex.

For demonstration purposes it might be best to review a less heterogeneous group. We think here of the group comprising three phobic,

dependent women, two schizoid men, and a psychosomatic man. In the first session the three fearful women nervously described their symptoms and then fell into a protective silence. The schizoid men muttered their introductions and sank into an isolated retreat. The floor was left to the therapist and the psychosomatic man.

The latter was a friendly, energetic, talkative person who rattled on for about ten minutes about his symptoms and his life situation. When he finished his competent and congenial narrative, the group fell into a prolonged silence. After two or three intensely long minutes of soundless hush the psychosomatic patient entered again with a question to the therapist. The patient then expanded on this topic for about five minutes. The tomblike silence resumed—interrupted only by the shifting of chairs and the rustle of smoking activity.

The therapist then intervened to comment on the silence and asked each patient in turn what his associations were to the topic introduced by the psychosomatic patient. The therapist concluded the session by reviewing the silence and explaining that he had intervened at the end to help the patients learn how to communicate in the group.

During the second meeting the same pattern repeated. Long silences developed. The tension clearly mounted during these lulls. The phobic ladies squirmed, looked uncomfortable, but kept silent. The schizoid men frowned, edged their chairs further toward the corners, and kept silent. The pressure on the friendly, talkative member would build up until he would finally begin to speak. He tried to get the others to talk. He asked them questions. He described at greater and greater length events from his own life (most of them concerning superficial events—hobbies, work experiences, etc.). By the fourth session the tension had mounted to an intense peak. The silences grew longer and more painful. The psychosomatic patient found himself involved in a series of monologues. It seemed that the patients were all getting disgusted with themselves and with each other, the one for talking too much and the others for not talking enough. By this point the talkative patient, in fact, found it hard to refrain from talking. When one of the others would venture a comment he would interrupt, ask questions, and relate his own associations. The executive outgoing patient had trained the others to be listeners. He later confessed that he rather fancied himself as a subleader in the group, and half-boastingly, half-sheepishly described his reflex skills in extroverted glibness.

The other group patients had successfully trained the extrovert to dominate them. They had forced him into a responsible, competent role and had thus emphasized and reinforced their own withdrawing tendencies. Their original reflex patterns had contributed to a tense

situation. The more the tension developed, the more they increased their reflex techniques for handling anxiety. The psychosomatic patient was almost frantically active and the others silent. They were all making a failure out of the group along the same lines of their life failures. When this reciprocal process had reached its optimal point, the therapist intervened to help the members to understand how they reacted to the tension and how they increased it by their reactions.

We expect each group member to contribute to the failure of communication that tends to develop in our therapy groups. This initial breakdown caused by the reciprocal principle is allowed to develop in the early stages in the group since it allows each patient to repeat his interpersonal imbalances in the therapy situation. The very real tension of the group situation provides valuable information about how each person handles anxiety. It is somewhat analogous to the transference neurosis of individual therapy. It provides material for many months of subsequent analysis.

This example centered around the reciprocal patterns of one member versus the group. More discrete interactions between pairs of individual patients inevitably develop and provide more complex and specific examples of the reciprocal process. Earlier in this chapter we have described a distrustful patient who was convinced that others were unsympathetic and mean to him. He provides another example of the reciprocal principle. We saw how this man easily and automatically provoked rejection and dislike by means of his growling suspiciousness. The hostile reception he received from the others led, of course, to an increase in his bitter distrust. He invited responses which led to a repetition of his original reflex pattern.

Reciprocal Relations Are Probable, Not Inevitable. The reinforcing process we have been describing is not an all-inclusive principle. It is a probability function. It does not necessarily hold for the individual interaction. Aggression usually breeds counteraggression. Smiles usually win smiles. Tears usually provoke sympathy. In specific cases, however, these general rules break down. Aggression can win tolerant smiles. Tears can provoke curses. But, when we study the thousands of interactions that make up each day of social existence, the principle becomes increasingly useful. Many kinds of variation and inconsistency operate to lower perfect predictability of interpersonal behavior. The meaning of the cultural context, the personality of the "other one," and oscillation tendencies in the individual are always complicating factors. Like any other principle which involves human emotions, the principle of reciprocal relations operates in probabilistic terms.

Effect of the Other Person's Personality. Reciprocal relations are more likely to develop with certain personalities. The principle holds most uniformly with pairs of symbiotically "sick" people. A phobic, dependent wife and a nurturant, strong husband would be such a pair. The more the husband takes care of her, the more the dependence repeats. The more the wife clings, the more pressure on the husband to be gentle and protective. Even in a symbiotic marriage of this sort, the reciprocity would tend to break down if other motives enter the behavior of either. If hostile reproach lies behind the wife's weakness, or impatient superiority behind the husband's strength, then new chains of interaction may develop.

Another aspect of this principle: The sicker you are the more power you have to determine the relationships you have with others. A maladjusted person with a crippled set of reflexes tends to overdevelop a narrow range of one or two interpersonal responses. These are expressed intensely and often, whether appropriate to the situation or not. Now a normal person has a fairly flexible range of reflexes. He can use any interpersonal response if the situation calls it out. He is less committed to and, for that matter, less skillful in the use of any particular reflex. When the two interact, it is the "sick" person who determines the relationship.

Suppose that the suspicious young man just cited meets up with a fairly well-rounded person. The latter may greet him cheerfully. The other may frown, or shoot a sharp glance, then cast his eyes to the ground. The normal person may invite the other to the movies—to which he replies with a sullen remark. No matter how flexible or well-meaning the one may be, the other will eventually force him to take a negative critical position.

The more extreme and rigid the person, the greater his interpersonal "pull"—the stronger his ability to shape the relationships with others. The withdrawn catatonic, the irretrievable criminal, the compulsively flirtatious charmer can inevitably provoke the expected response from a more well-balanced "other."

The flexible person can pull a greater variety of responses from others—depending on his conscious or unconscious motives at the moment. He can get others to like him, take care of him, obey him, lead him, envy him, etc. The "sick" person has a very narrow range of interpersonal tactics, but these are generally quite powerful in their effect. I have seen compulsive, responsible group members after several months of treatment desperately trying to get the other group members to understand and commiserate with their inner feelings of weakness and despair. They had trained them well to look up and

respect them. Their own managerial reflexes kept firing even at the moment they were verbally appealing for help and sympathy.

Variation Within the Individual Affects Reciprocal Relationships. Another qualification of the principle of reciprocal relations must be included. In describing human behavior the impression is often given that a consistent line of adjustment is exhibited. In most of the illustrations used in this chapter, the subject's role is made to appear fixed. Actually, we know that inconsistency and changeability are the rule and not the exception in human emotions. The factors of change and stability will come under detailed survey in Chapter 13. They are, indeed, studied as a separate dimension of personality—the variability dimension. Included under this topic are all the measurable variations which affect human behavior—changes in cultural context, changes over time, changes due to conflict and variety among the levels of personality.

At this point it is sufficient to point out that no interpersonal role is absolutely pure or rigid. The most withdrawn catatonic sends out occasional tendrils of affect. The most hardened criminal occasionally has a moment of congeniality. The most autocratic five-star general occasionally admits he is wrong. Most people show considerable conflict or inconsistency in their actions from time to time. No matter how thick and effective the reflex defenses, underlying inconsistencies eventually manifest themselves.

When this happens the principle of reciprocal relations tends to break down. The probable accuracy of the predictions drops. A flirtatious woman provokes seductive responses from a man. His approaches set off stronger flirtatious actions. The man becomes more seductive. At some point in this process underlying motives may step in to change the pattern. In some cases, a flirtatious façade may cover deeper feelings of competition or contempt toward men. The woman would then shift to behavior which Erickson describes as "bitchy," and rejecting. The reciprocal pattern of entice versus seduce would shift. The man's reaction would then vary depending on the nature of his multilevel pattern. He might continue to seduce, he might be hurt, he might become dependent.

The same process of circular interactions leading up to an intense breaking point often occurs between parent and child. Dependence pulls nurturance which provokes further dependence—. In some cases the spiraling increase in intensity leads to a temporary crash. At some point the parent's underlying feelings of selfishness or self-protection lead to refusal. Father comes home one night tired and

grumpy. Outside events may have set off underlying feelings of deprivation, or self-pity, or sadism. He may snarl at the child. The child then whines. The whining might increase the father's irritation. A new series of reciprocal events may thus be initiated.

Alternation of behavior is, of course, not an unhealthy manifestation. Moods shift; we carry over the feelings from one situation into another. Events of the day set off underlying effects which may be quite different from the current reality situation. It is safe to suggest that everyone acts inappropriately many times each day. These inconsistencies can hardly be considered abnormal. The lines of interpersonal communication are constantly breaking down momentarily, but these involve no permanent disasters. A healthy father-child relationship is not paralyzed because one of the two has a "bad day" or carries over inappropriate effects.

On the other hand, very rigidly formed relationships can be upset badly by shifts in the pattern of reciprocal relations. Some institutional relationships are very inflexible and demand perfect reciprocity. The army officer expects to provoke consistent obedience. A rent in this kind of interpersonal fabric can be seen as unforgivable. Some kinds of symbiotic marriages are so rigid that deviation in reciprocal roles can cause intense anxiety. When a servile, docile husband shows a flash of rebellion against a dominating wife, the results can be explosive.

Thus, we see that many factors tend to qualify the principle of reciprocal relations. Among these we have considered variations in the cultural context, variations in the personality of the "other one," and variations due to multilevel ambivalences in the subject's personality.

Multilevel Reciprocity Patterns. We have very little systematic knowledge about interpersonal relations. We do know that a most complex, shifting matrix of forces operates in the simplest interaction. Throughout this book we are forced to limit the theory, the illustrations, and the measurements to the simplest forms of interaction. One example of a rich and vital phenomenon which is at present beyond reach of our system has to do with multilevel reciprocal patterns. Complex patterns of interaction exist at all the levels of personality. In some cases the smooth flowing exchanges of one level are threatened and destroyed by clashes caused by underlying variations. That is, two people may interact in a most automatic and rewarding pattern at the level of the interpersonal reflex. The seductive man and the flirtatious woman is one such situation. At the private level the feelings of both partners may be quite different. The man may have

TABLE 2

PERCENTAGE OF DIAGNOSTIC TYPES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

		Percentage of Cases Diagnosed as								
Institutional or Symptomatic Sample	*N*	Managerial-Autocratic *AP*	Competitive-Narcissistic *BC*	Aggressive-Sadistic *DE*	Rebellious-Distrustful *FG*	Self-Effacing-Masochistic *HI*	Docile-Dependent *JK*	Cooperative-Overconventional *LM*	Responsible-Hypernormal *NO*	*Total*
Psychiatric Clinic Admissions	537	15	6	11	12	13	12	9	22	100
College Undergraduates	415	45	9	3	3	2	2	3	33	100
University Psychiatric Clinic	133	13	10	10	17	13	8	6	23	100
Middle Class Obese Patients (Female)	121	30	10	4	3	2	5	10	36	100
Overtly Neurotic Dermatitis Patients	31	23	0	10	13	16	10	6	23	101
Self-Inflicted Dermatitis Patients	57	25	7	2	7	7	5	14	33	100
Unanxious Dermatitis Patients	71	37	7	3	3	7	3	11	29	100
Group Psychotherapy Patients	109	13	4	7	24	16	11	6	19	100
Individual Psychotherapy Patients	49	8	10	6	12	23	16	12	12	99
Ulcer Patients	39	20	5	8	0	3	5	10	49	100
Hypertensive Patients	49	18	2	2	0	7	5	12	54	100
Medical Control Patients	37	35	8	0	3	5	5	5	38	99
University Counseling Center (Male)	93	38	4	2	4	3	2	8	39	100
University Graduate Students (Male)	39	31	21	0	13	0	5	0	31	101
Stockade Prisoners (Male)	52	19	13	15	10	2	6	10	25	100
Hospitalized Psychotic Patients	28	14	11	11	14	11	21	4	14	100
Officers in Military Service	39	46	0	0	3	0	0	3	49	101
Total	1899									

deeper sadistic motives toward women. The flirtatious girl may have underlying needs to reject and humiliate men. What starts off as a most spontaneous and fluid friendship eventually ends in a brawl. The underlying feelings of the participants do not lend themselves to a durable relationship.

This aggressive ending might not occur if the underlying feelings of the partners were reciprocal. Suppose that the woman's underlying feelings, instead of being competitive and rejecting, were masochistic. Their surface reflexes blend nicely into the pattern of seduce and entice. Their deeper feelings would, in this case, also blend nicely into the reciprocal pattern of sadism-masochism. The man's preconscious aggressiveness would tailor nicely into the woman's private needs to be aggressed upon. It is possible that many symbiotic marriages exist in which multilevel needs of both mates fit together into multilevel patterns of reciprocity. Our measurement methods are far from being able to tap these intricate networks which seem to characterize even the simplest relationships.

Incidence of Level I-M Behavior in Various Cultural Samples. A summary of the research findings concerning Level I behavior is presented after each of the eight clinical chapters (Chapters 15–22). At this point, to give an overview, it may be helpful to list the percentage of Level I-M types found in several institutional or symptomatic samples.

In the preceding chapter a method was described for summarizing interpersonal behavior at any level in terms of a single point on the diagnostic grid. The location of this summary point determines the interpersonal diagnosis (see Chapter 12). Thus if the resultant of the Level I scores for an individual locates in the *AP* octant he is diagnosed as a Managerial-Autocratic personality at this level. Table 2 presents the percentage of cases in fifteen samples falling in each octant at Level I-M.

A detailed re-examination of these data will be found in later chapters, but some of the meaning of Level I-M behavior can be derived by inspection of the table. Some samples (military officers, normals, psychosomatic cases) emphasize strong, hypernormal facades (octants *AP* and *NO*). Those samples which include people in trouble (prisoners, psychiatric patients) manifest more alienated or passive behavior (octants *DE*, *FG*, or *HI*).

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8

The Level of Conscious Communication: The Interpersonal Trait

This chapter is devoted to an examination of Level II, the data of conscious description. We deal here with the individual's perceptions of himself and his world as he reports them.

Like the other levels of personality, this one is automatically defined by the data which contribute to it. There is only one criterion for determining Level II data: conscious verbal report by the subject. We are interested in *what* the subject says, the content of his verbal expressions. From these we focus on the interpersonal themes which he attributes to himself and to "others." From these we obtain the variables of Level II.

It must be noted that the consensual accuracy or truth of these verbal reports has no bearing on the definition of the level. If the subject says he is *popular*, the appropriate Level II code for this interpersonal role is assigned. Now dozens of observers may agree that he is quite unpopular with his associates. This fact shows up on our diagrams for Level I. But the Level II rating concerns not what he does, not what he privately thinks or wishes, but what he *says*.

This is called the level of *conscious description* because it reflects how the subject chooses to present himself and his view of the world. It will be noted that we do not call it the level of consciousness, but of *conscious communication.* This is an important distinction. The phenomenon of consciousness is one of the most elusive issues in the history of Western thought. One of its most confusing aspects is, of course, its subjective nature. The scientist can never understand or measure what another person has in his consciousness. It is often quite difficult for the subject himself to know the focus and limits of his awareness. Between the subject and the psychologist there exists any number of potentially distorting factors—deliberate omissions, expres-

sive inaccuracies, and the like. And we never know the exact level of awareness from which the statements come.

Since it is impossible to obtain an objective evaluation of the subjective viewpoint of another person, many psychologists have attempted to discard the whole issue of consciousness. But in so doing an essential dimension of human behavior is lost.

Two principles must be applied to any scientific approach to the conscious aspects of personality. The first is the classic solution developed (but not utilized) by the earliest behaviorists: treat the subject's introspection not as the essence of truth, but as a behavioral expression to be evaluated in the light of all the other measurements. The second principle is an explicit corollary that can only develop from a systematic multilevel analysis of behavior. It holds that the data of conscious report have of themselves an ambiguous meaning until they are systematically evaluated in the light of the data from the other levels of behavior.

At Level II we deal, therefore, with conscious reports and not consciousness. We define it operationally in terms of all the statements an individual makes about himself or his world. We employ it and evaluate it in relation to other levels of personality.

The Attributive Nature of Personality Language

Transcriptions of everything that a patient says during an hour of psychotherapy provide one source of raw data for Level II measurements. The patient's testimony in this form can then be studied from the standpoint of the interpersonal system. Everything that the patient says about himself becomes Level II "Self." Everything he says about the people in his interpersonal world becomes Level II "Other." The accuracy, the deeper significance, the immediate purpose behind these responses is disregarded. Their direct surface meaning is the essence of the Level II classification.

In studying the verbal content of these descriptions an interesting fact develops. They are all attributive or adjectival. They are all significations. They can all be interpreted as assigning a quality to the self or the world. They can, thus, be reduced for analysis to a descriptive adjective or to adjectival phrases. The interpersonal context of everything that is said about oneself or one's world can be translated into a generic attributive form: "I am a _____ person, in relationship to _____."

Take, for example, the patient's testimony, "I was really angry at my boss today. I took it docilely for a while. Finally I insulted him. I've always hated his guts." The subject and object of this interpersonal relationship are clearly self-boss. The four sentences vary

in their mode of expressing the interpersonal theme—adjective, verb, participle—but they can all be translated into the attributive formula:

I feel like an: { angry / docile / insulting / hating } person in relationship to my boss.

At the level of conscious description we deal with the subject's language about himself and others. The interpersonal attributes are the specific rated units. The interpersonal themes expressed in these significations are coded according to the matrix of sixteen variables and provide a systematic summary of the subject's view of himself and his world. The operational procedure for defining a level in terms of the source of the language is not unique to this level. It is now possible to look back at the Level I reflex communications and see that they are also defined by the source of the language—the attributive significations *of the observers* who rate the subject's behavior. At Level I we do not deal with the reflex conversation of gestures itself but measure its effect on others. We ask the individuals who observe or interact with the subject to make attributive statements about him which reflect his social stimulus value. The language by which the subject is described, by others or by himself, comprises the data for Levels I and II respectively.

The data from Level I can therefore be translated into the same type of attributive formula. "*He* is a _____ person in relation to _____. This systematic approach to the linguistics of personality provides a direct method for comparing the levels of personality. The relationships between levels—discrepancies, concordances—define another dimension of personality, the variability dimension. The direct measurement of these mechanisms which thus relate the levels of personality is made possible by the rigorous analysis of the language of personality.

The Measurement of Interpersonal Attributes

The unit with which we measure the language of conscious description is called the *interpersonal attribute* or the *interpersonal trait.* These terms have been selected because they reflect the adjectival or attributive nature of the Level II data. We classify Level I behavior in terms of interpersonal reflexes, gestures, or mechanisms. We classify Level II behavior in terms of the interpersonal attribute or trait.

The interpersonal trait of Level II is formally defined as the interpersonal motive attributed by the subject to himself or another in his

conscious reports. Every discernible or ratable interpersonal theme in the content of the individual's verbalizations defines a unit of Level II behavior.

The themes or categories employed are derived from the circular continuum of interpersonal variables. It will be recalled that in measuring the subject's reflex behavior an inexhaustible list of sample verbs was held to apply to each of the sixteen generic interpersonal purposes. The same procedure is followed for measuring attributive behavior of Level II. The interpersonal traits were developed by simply



FIGURE 6. Interpersonal Check List Illustrating the Classification of Interpersonal Behaviors into Sixteen Variable Categories.

replacing the verbs of Level I with the coordinate or appropriate adjective. The adjectives which go with the reflex (i.e., verb) *to complain* would obviously include *complaining, resentful, bitter,* etc. The adjectives which parallel the reflex *to love* would be *loving, affectionate,* etc. This translation of verbs into adjective equivalents is not always so linguistically simple. There are many interpersonal reflexes for which equivalent adjectives do not exist. Extensive methodological procedures have been carried out in order to deal with these technical difficulties. As a result of these exploratory studies, the interpersonal meaning of most words in the English language which have a social connotation has been determined in terms of the sixteen-point continuum.

Several adjectives characteristic of each generic interpersonal trait (i.e., each point on the circular continuum) are included in Figure 6. These adjectives are suggestive and illustrative. They are by no means exhaustive of the entire range of traits which fit each point of the circle. In analyzing the traits employed by an individual, we rate not only the kind but the intensity of each attribute. Extreme, inappropriate, and maladjustive interpersonal behaviors are thus distinguished from the moderate and appropriate. The general nature of these adjustive and maladjustive traits is suggested by the words listed in the inner and outer rings respectively in Figure 6.

Four Methods for Measuring Level II Behavior

In Chapter 6 it was pointed out that several methods exist for obtaining the data for any level. Whenever Level II data are being discussed it is necessary to indicate the specific source—that is the operations through which the data were derived.

When trained personnel rate the verbal content of diagnostic interviews, i.e., the patient's descriptions of himself and others, the resulting data are assigned to *Level II-Di.* These ratings are made from on-the-spot observations, notes, recordings, or transcriptions.

When trained raters judge the verbal content of therapy interviews (group or individual) the descriptions of self and others are coded *Level II-Ti.*

Scores from the Interpersonal Adjective Check List on which the patient rates his view of self and others are coded *Level II-C.*

Ratings by trained personnel of the conscious descriptions of self and others taken from autobiographical essays written by subjects are coded *Level II-A.*

There are, then, several methods for obtaining Level II data. The essence of them all is that we get the subject to describe himself and others. These reported perceptions are then scored in terms of the

circular continuum. If the data are obtained through fixed, prepared test stimuli-questionnaires, check lists, and the like, predetermined ratings assigned to each test item make the scoring automatic. If the data come from free responses—conversations, interviews, autobiographies—then two or more trained technicians independently rate each interpersonal reference.

The rating of interpersonal attributes at the level of conscious description is illustrated in the following examples:

The scoring of interpersonal traits at the conscious level. To illustrate the rating of interpersonal traits at the conscious level, there follow examples of ratings of an adjective check list, the content of therapy sessions, and an autobiography.

a. The Scoring of Interpersonal Traits as Applied to an Adjective Check List, Level II-C:

Adjective	*Trait*	*Intensity*
stubborn	*B*	3
proud	*B*	2
bossy	*A*	3
good-leader	*A*	2
reserved	*H*	2
withdrawn	*H*	3

b. The Scoring of Interpersonal Traits as Applied to the Content of Discussion of a Group Psychotherapy Session, Level II-Ti:

Other		*Self*
	And since I've been married I've been able to make a substitute, a transference of these feelings from my mother to my wife. I guess I *depend* on my wife a lot, more than I	*K-3*
C-3, *A*-2	should. She is a *strong* person. She admires strength. I think it makes her *retract, withdraw* from me when I am *dependent* on her. This makes me feel worse. Then she	*K-3*
C-3, *A*-2	tries to *drive me*. She's an *ambitious* person. It makes me feel very *helpless*. This is a real vicious circle and it has me worried.	*I-3*

c. The Scoring of Interpersonal Traits as Applied to an Autobiography, Level II-A:

Other		*Self*
	I guess I was a *very co-operative* child, but this is just from what I've heard. I've always been *timid* all my life. This is	*L-3* *I-3*
A-2	especially true with girls. I believe my parents realized this and often, especially my mother, tried to *push me* a little which I resented and probably *went out of my way to do*	*B-3*
A-3	*the opposite*. I have always *resented* and still do, being told what to do or obviously *being led*.	*F-3*

The simplest and most standardized method for obtaining an estimate of Level II perceptions is to employ the Interpersonal Adjective Check List. This test has been specifically designed by Robert Suczek, Rolfe La Forge, and others to fit the matrix of the sixteen interpersonal variables. In its present form (Form IV) it consists of 128 adjectives, 8 for each point on the circle (see Appendix 2). The check list is calibrated in four degrees of intensity and the array of adjectives is balanced according to the expected frequency of usage. The patient simply checks all of the items which he believes describe his behavior. Since each term is already prescored, his responses automatically produce his Level II-C self-pattern.[1] The patient can be asked to use the same check list to rate the significant "others" in his life. This gives a standardized picture of his own description of self and world.

The Patient Diagnoses Himself

Let us consider some illustrations of Level II measures from a clinic patient with a history of chronic maladjustment. The data were collected from the Interpersonal Adjective Check List Form IV on which the subject (at the time of entrance to the psychiatric clinic) successively rated himself and his family members.

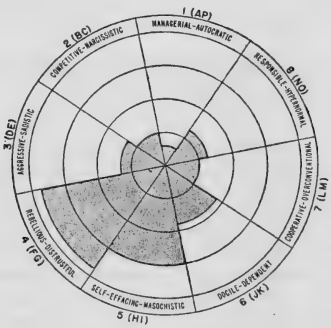


FIGURE 7. Level II-C Self-Description of Illustrative Subject Based on Interpersonal Check List. *Key:* Radius of circle equals 16 check list words.

Figure 7 presents a diagrammatic summary of his self-descriptions. It is clear that the patient sees himself as an "unbalanced" person. He has consistently checked himself as being distrustful, passively hostile, and isolated. The marked imbalance indicates that he claims these

[1] A table of norms for converting Level II-C dominance and hostility indices into standard scores will be found in Appendix 5.

traits to the extreme degree, thereby diagnosing himself as disturbed in his interpersonal behavior. Turning our attention to the interpersonal themes that he does not attribute to himself (the blank area of the circle) we see that he clearly denies all the affiliative (*K, L, M, N, O*) and strong assertive (*P, A, B, C*) feelings.

We have here the patient's self-diagnosis—a most important slice of the entire personality pattern. The Level II-C self-profile has considerable clinical significance. Several probability laws hold for this single measure.

A Patient Diagnoses His Family Members

The patient's descriptions of his family members provide another set of valuable data. Considering his view of his father (Figure 8), two statements are immediately pertinent: (1) he diagnoses his father as a distrustful (*G*), passively hostile (*F*), and isolated (*H*) person; (2) he sees his father as being very much like himself. It is important to note

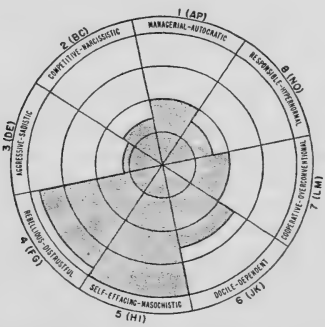


FIGURE 8. Level II-C Conscious Description of Father by Illustrative Subject Based on Interpersonal Check List. *Key:* Radius of circle equals 16 check list words.

the difference between these two statements. To borrow the vocabulary of the logician, the first is a *class* statement about a single area of personality, his view of his father. The second is a *relationship* statement comparing two discrete areas of personality—Level II-C "Self" versus Level II-C "Father."

Turning to this patient's view of his mother (Figure 9) we observe a contrast. The mother is seen as unyielding (*B*), rejecting (*C*), and punitive (*D*) to an extreme degree. He does not attribute any affectionate or passive qualities to her. Comparing the view of mother with

his own self-perception (shifting thereby from a class to a relationship context of discourse), a marked discrepancy becomes apparent. He sees himself as being like his father but unlike his mother.

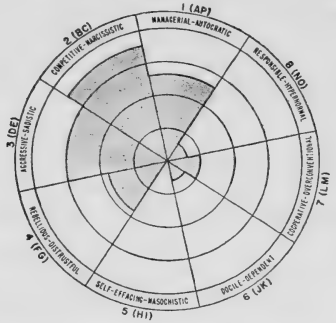


FIGURE 9. Conscious Description of Mother by Illustrative Subject Based on Interpersonal Adjective Check List. *Key:* Radius of circle equals 16 check list words.

Level II Provides a Measure of Conscious Identification

By inspection or by quantitative comparison we can determine the similarity-difference factors relating the self-profile to the Mother and Father circles at Level II. These relationships comprise the network of measurable phenomena called variability indices, which serve the function of relating the areas and levels of personality. We have suggested here that the relationships between Level II Self and Level II Other can be called identification or disidentification. To illustrate some of these relationship mechanisms as they operate at this level of personality we shall construct a diagrammatic summary of this patient's Level II perceptions (see Figure 10). The lines linking the summary points provide a linear index of the arithmetic discrepancies between the areas of personality involved. The longer the line, the greater the difference in interpersonal themes attributed to the persons in question. It is then possible to translate this diagram into a verbal summary of the Level II behavior, employing the useful, but semantically suspect language of the clinic.

It might be said that this patient sees himself as exploited and rejected in relationship with an unsympathetic and cold mother. He is consciously *identified* with a weak and distrustful father. He is consciously *disidentified* with his mother.

The patient's view of his wife (see Figure 10) adds another factor to the picture. He tells us that she is a hard-hearted, hostile, and rejecting person. He consciously *equates* his wife with his mother, at-

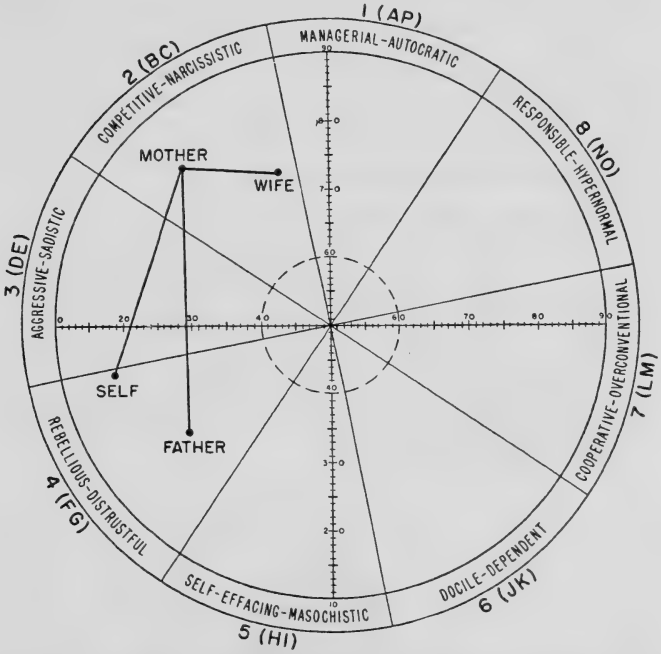


FIGURE 10. Diagnostic Summary Profile of Level II Self and Other Scores for Illustrative Patient. *Key:* The center of the diagnostic circle is determined by the mean of a clinic sample of 800 cases. The placement of the three summary scores is determined by trigonometric formulas (see Chapter 6) which yield horizontal and vertical indices. These are converted to standard scores. The lines between the summary points provide linear estimations of the amount of conscious identification or disidentification (see Chapters 6 and 13).

tributing the same interpersonal motives to both. A wealth of clinical cues is summarized in the family descriptions. From them we obtain the patient's conscious diagnosis of his own oedipal situation, his marital relationship, and his relationships with three central figures in his life. Many probability laws hold for each of these measures. His

view of parents is correlated with psychiatric diagnosis, symptom, and with the intensity and type of underlying conflict.

In one sense these systematic measurements are quite limited. A clinical interview would give the same data just as easily and would provide a much more rich, specific, and sensitive registry of these facts.

The circular profiles have some compensating virtues—they are reliable, they are quantitative, and they are standardized and calibrated in terms of the sixteen variables by which we measure interpersonal behavior at other levels. This means that we can directly compare the different perceptions which the patient reports. They allow us to build up a series of probability laws which hold for each level and for the relationships among levels.

Level II Presents the Patient's View of the "Transference" Situation

We have reviewed how a patient entering the Kaiser Foundation Psychiatric Clinic diagnoses himself and his family members. The relationships among these measures have provided indices of conscious identification and conscious equation. When the intake evaluation was completed, this patient began psychotherapy. After nine hours of treatment he filled out the Interpersonal Check List on his therapist. This gives us his conscious description of the therapist (Figure 11). The patient diagnoses the doctor.

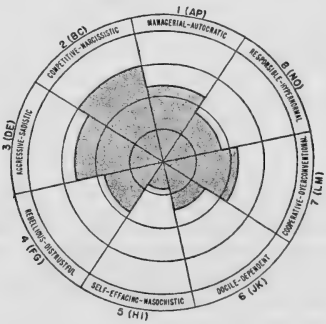


FIGURE 11. Level II-C Description of Therapist by Patient Illustrating a Measure of (Conscious) Transference. *Key:* Radius of circle equals 16 check list words.

This patient reported his therapist (Figure 11) as a well-balanced person. He did not use intense or one-sided descriptive terms. He attributed moderate themes of strength (*A*), punitive firmness (*D*),

and mild rejection (*C*) to his therapist. A mild negative transference at the conscious level is apparent.

When the view of therapist is compared with his pretreatment view of self, we see that the patient is disidentified with the therapist. He reports his therapist as being much more like his mother and his wife (Figure 12).

Self	bitter and depressed	⟷	Mother Wife Therapist	cold and punitive

In this manner the patient gives us a systematic picture of his oedipal and his transference situations—*from his own viewpoint.* The patient's reports about these relationships may be quite different from the therapist's. The latter might not consider himself as being cold and strict with the patient. If the patient's description of his therapist is consensually inaccurate, this fact takes on a considerable importance in understanding the treatment relationship. The relation between the patient's view of another and the consensual view of that person allows for an operational definition of a classic defense mechanism—*projection.* Where this inaccurate perception involves the therapist, we have obtained a measure of *transference-projection.*

Therapists Can Measure Their Own Misperceptions

The Kaiser Foundation research project has undertaken extensive studies of process in psychotherapy. The aim of these studies is to apply the interpersonal system to the therapeutic interaction and to the perceptions of the patient and therapist. The working principle employed in these studies is: the patient and therapist comprise a basic interacting unit. We do not study the patient in therapy, but both the patient and the therapist as they interacted. These therapeutic studies cannot be included in this diagnostic monograph, but they are worth brief comment here because they illustrate the application of Level II measurements.

One procedure commonly employed is to have the therapist fill out an Interpersonal Check List on his patient. This gives us a most interesting measure. It tells us how the therapist sees the patient with whom he is in relationship. Figure 12 presents the therapist's picture of the patient we have been discussing. The circle tells us that the therapist sees the patient as deferent (*I*) and dependent (*J*). Now this description may or may not be consensually accurate. Regardless of its "pull," it does summarize some valuable information—it tells us something about the conscious *countertransference.*

We recall that the patient described the therapist as cold and rejecting. This implies a certain fear and passive hostility on the part of the patient. He feels mildly rejected. The therapist sees the patient as mainly weak and dependent. This suggests certain discrepancies in the communication pattern between the two. The therapist might fail to sense the patient's feelings of deprivation, and assume deference and collaboration.

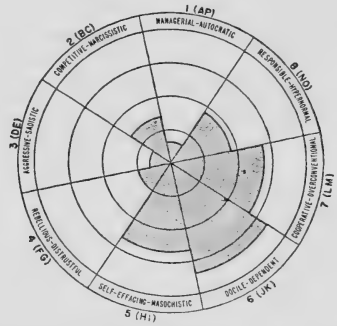


FIGURE 12. Level II-C Description of Patient by His Psychotherapist Illustrating a Measure of (Conscious) Countertransference. *Key:* Radius of circle equals 16 check list words.

Fitting together the reciprocal perceptions by both members of the relationship often reveals striking breakdowns in communication. Projection and perceptual distortion on the part of patient and therapist often become apparent by the use of Level II measures.[2]

This discussion brings us to a tricky problem of definition. We have been talking about Level II behavior—the conscious descriptions of self-and-other by the patient. When we introduced the therapist's view of the patient we complicated the issues. From the standpoint of the patient, the therapist's view-of-patient is Level I. The therapist is thus an outsider rating the patient.

But in any study of therapeutic interaction we focus equally on patient and therapist. The therapist's view of the patient is a Level II Other measure from the standpoint of the therapist. Studies in interpersonal relations which attempt to use multilevel patterns of response can become quite complex since we must study both sides of

[2] A most ingenious research which illustrates the phenomenon of countertransference, as measured by the interpersonal system, has been completed by Richard Cutler (1). This research deals with misperception of self and others in the psychotherapeutic situation.

the transaction. A's report of B is subjective (Level II) from the standpoint of A, but it is objective (Level I) from the standpoint of B.

The specific definition, conceptualization, and clinical meaning of these relationship variables (e.g., identification, projection) need not be taken up in detail here. In the context of this discussion of Level II behavior it need only be suggested that the relationships between self-perception and perception of "others" have considerable importance. Lawful connections do exist between these self-and-other circles. Patients who describe themselves as distrustful and isolated tend to present predictable pictures of their parents and the significant "others" in their lives. So do the patients who assign themselves to other extreme positions on the Level II circle.

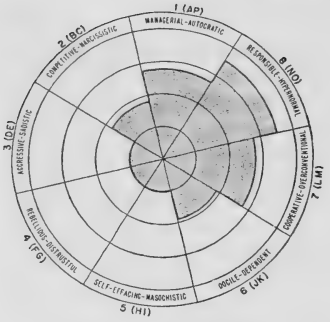
A host of low-order predictive functions can be called into play if we obtain this one type of personality measure—a patient's conscious description of self. It should be kept clear that these are not foolproof prognostications. They are probability statements which allow us to make such predictions as, "If the patient describes himself as *sweet* and *docile* (*JK*), the chances are 5 to 1 he will attribute to at least one parent idealized, tender nurturance, and the chances are 2 to 1 that he will see both parents in this way." From Level II Self-description alone we obtain a large but loose network of low-order probability statements which make predictions about other levels and areas. This is interesting theoretically, but of restricted practical value. When we add the data from another level or area—his view of parents, for example—the additional evidence tightens up the network of relationships. It increases the complexity of the personality structure in a geometrical rather than an arithmetical proportion. That is, it multiplies the permutations and combinations of relationships. It also increases the accuracy of prediction.

Use of Level II Patterns in Child Guidance

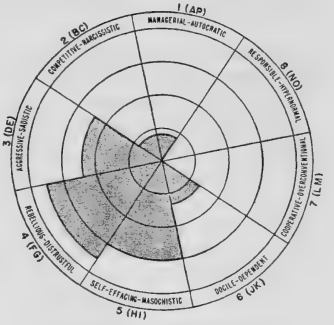
We have stressed the point that Level II conscious descriptions are the most simple, straightforward measures of personality and their maximum usefulness is found in combining or comparing these conscious reports with other levels.

In child guidance, Level II patterns seem to have an especially valuable application. Diagnostic evaluation of children's cases is a complex process. One of the difficult aspects of this procedure is caused by the multiplicity of interpersonal relations involved. Understanding the child's situation requires some knowledge of the child, his siblings, both parents. Often the parents' attitudes toward child-rearing are closely related to their own parents. Thus, a three-generation matrix of relationships can be involved.

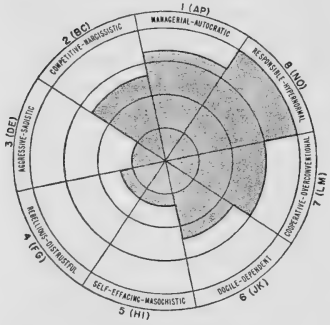
Mother's view of:



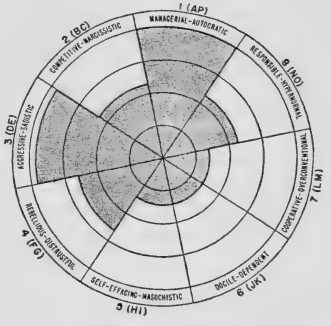
MATERNAL GRANDMOTHER



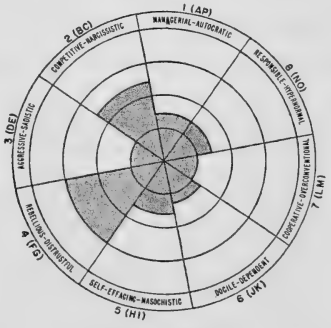
MATERNAL GRANDFATHER



MOTHER BY SELF



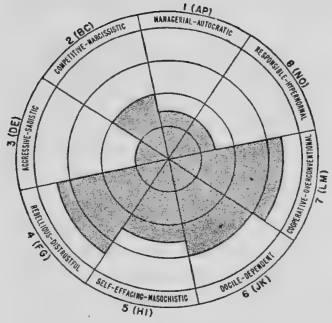
MOTHER BY HUSBAND



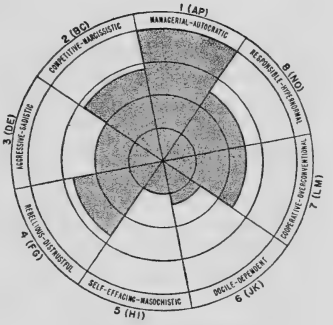
CHILD BY MOTHER

FIGURE 13. Familial Pattern of Interpersonal

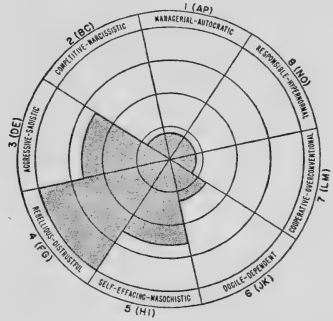
Father's view of:



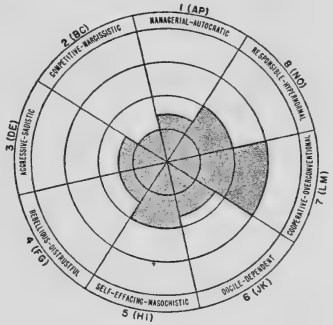
PATERNAL GRANDFATHER



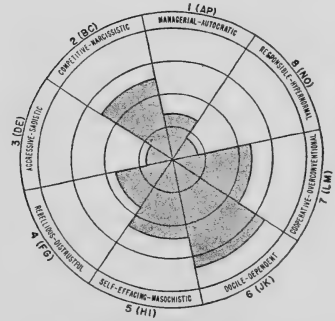
PATERNAL GRANDMOTHER



FATHER BY WIFE



FATHER BY SELF



CHILD BY FATHER

Relations for Child Guidance Evaluation.

A convenient way to systematize these patterns is to obtain Level II-C descriptions from both parents. The mother, for example, is asked to rate herself, her husband, her child, and both of her parents. The husband does the same. As indicated in Figure 13 a matrix of ten ratings is obtained. This three-generation pattern of interpersonal scores provides a large number of cues for understanding the child and his emotional background.

The family constellation diagrammed in Figure 13 reveals that the mother sees herself as responsible, generous, and hypernormal; that she sees her child as rebellious and passive-resistant, her husband as being like the child. She describes her mother as being a strong, responsible figure and her father as being a bitter and defeated man. The father, on the other hand, describes the child as being less rebellious—which suggests that most of the friction (and perhaps the motivating force in bringing the child to the clinic) centers around the mother. The father tends to see himself like the child and like his own father. He describes his wife as being very much like his mother. A fairly wide discrepancy exists between the wife's self-description and her husband's view of her—he attributes much more hostility and bossiness to her than she admits. This interwoven pattern of mutual misperception and oedipal themes suggests several hypotheses which may be useful in understanding this family's situation and the problems which led the parents to bring the child to the clinic.

According to Mary Sarvis (2), it is not unusual to find that the parents have quite different perceptions of the child, or that a certain personality formation characteristic of a grandparent has skipped a generation and reappeared in the child.

When these scores are compared with each other, a complex network of discrepancy indices can be derived. We can measure the difference between the husband's view of himself and his wife's perception of him; or the similarity between the wife's view of her father, her own husband, and the child. These relationships will be given operational definition and further theoretical consideration in Chapter 13, which deals with the measurement of variability indices.

Variability and the Sublevels of Consciousness

At the end of the last chapter, it became necessary to consider the objection that our clinical measurements are infinitesimally narrow contrasted with the broad variety of human behavior. In each different situation and at every point in time we deal with a changing organism. Our measurements, however elaborate, are generally limited to a restricted range and to a fleeting span of time. It has been suggested that the predictions be limited to the context in which the

measurements are made. The Kaiser Foundation system is a functional clinical system. By aiming our predictions at the further behavior of the patient in the clinic, we use our information in the same context in which it was collected.

Now, as we come to the close of this chapter, we are faced again with the same issue. The range of conscious reports is diverse. A person describes himself in a variety of ways, depending on his purposes and the environmental situation. He will emphasize certain trends when he attempts to impress, others when he attempts to excuse himself, others when motivated to confide. How do we know that the measurements of Level II we make in one or even several moments of time reflect the over-all scope of the individual's conscious perceptions? Of course, we don't know. Here we must resign ourselves to the familiar indeterminism. We can never hope to sample the breadth of the individual's self-descriptions as they vary in time and context.

There are, fortunately, several steps which can be taken to limit our ignorance. The first of these derives from the organismic premise that no datum of personality can be evaluated except in the context of the total organization. The tenor of our conscious reports is, as we well know, related to the Level I situation. *What* one says depends upon what one *purposes*. It depends upon the pressure of the social environment. Let us illustrate. Consider an initial treatment interview in which the therapist is reflexly and unconsciously pushing the patient to free-associate and confide. Let us assume that the interview has been recorded and the independent judge rates this behavior as *directive* (*AP* at Level I Other) behavior. Let the patient be *B* (stubborn, resistive). We shall skip the question of responsibility for initiating the relationship, i.e., who provoked whom to develop these roles. In most relationships this is a mutual process of training each other. In this context, the therapist might make a brief didactic remark to the effect that people sometimes have feelings about their childhood or about their parents that are important. The patient might produce the conscious description of self and other that she has nothing but the most loving feelings toward her parents who have always been kind and good to her. The following oversimplified formula has developed:

Self (*Patient*)			*Other*
Level I	*B*	⟷	*AP* (therapist)
Level II	*M*	⟷	*O* (parents)

We verbally summarize by saying: "When the patient is being resistive or defensive to a directive therapist, she reports herself as affectionate to her idealized parents. Let us go on to assume that the

therapist works through this power struggle and that by the twentieth treatment interview a participant phase of the relationship is developing. The therapist is communicating support (N), and the patient is attempting to be cooperative (L). In this context she might confide, "Many times I have been disappointed and hurt by my parents' unwillingness to understand me and my point of view." The formula for this sequence becomes:

Self			*Other*
Level I	L	$\longleftrightarrow$	N (therapist)
Level II	G	$\longleftrightarrow$	C (parents)

This translates back to the verbal summary: When the patient is confiding and cooperative to a supportive therapist, she describes herself as rejected by her parents who are seen as unsympathetic.

Here the content of conscious report has shifted dramatically in relation to the interpersonal purposes involved. If, however, we had drawn hard and fast diagnostic conclusions after the first interview, a most incomplete picture would have developed. A working rule thus develops. The data of conscious report must be studied in the light of the three standard sources of variation: time, the interpersonal context, and variation among the levels of personality. The last, which defines structural variation, involves the relationship between the levels of self-behavior. In the illustration we have just considered, we focus on the interpersonal context in which the parents were described. The patient's Level I purposes shifted from defensive disagreement to cooperation, as the social environment, in the form of the therapist, shifted its directive pressure.

It follows that one control over the variability in conscious description is obtained by indicating the organism—world matrix from which the data come. Since patients give us their views of self-world in the context in which we wish to employ the data—i.e., in the clinic—the functional criterion enters again as a second useful control over variability. By pointing our predictions to future behavior in the clinic, we keep constant, or at least more constant, the situational factor. The advantage of limiting our predictions to the functional nexus has already been considered in the preceding chapter. They are equally applicable to the problem of Level II variation.

A third partial solution to the issue of variation involves technical procedures in the collection of data. There is a wide variety of methods for obtaining Level II material in the clinical situation—interview, check list, autobiography, etc. They range from the personal revelation at the most intensive moments of psychotherapy to mechanical se-

lection of "yes" or "no" items on a questionnaire. For a complete evaluation of personality, we optimally obtain as many different types of self-report as possible—as the subject varies in response to the most free through the most controlled stimuli, from the most confiding to the most defensive motivations.

In this way we tap not just the patient's self-description as revealed by one Level II measure—but rather a range of Level II behaviors. If the same self-description emerges from all the measures, then we can be fairly certain that we have a durable estimate of Level II. If it varies among the different sublevel measures, then we have an estimate of the changeability of the self-description and the way it varies.

Figure 14 provides a hypothetical Level II variation in *depth* of conscious reports in different cultural contexts. The problem of variability, which we have raised here, is discussed in detail in a later section of this book.

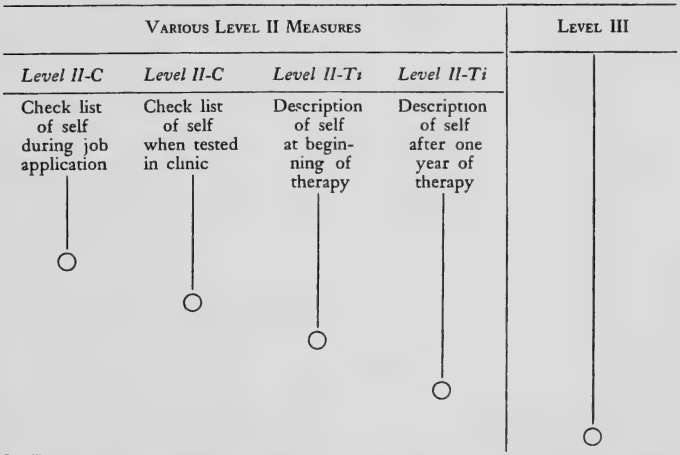


Figure 14. Hypothetical Variation in Depth of Level II Measurements Due to Change in Cultural Context.

Incidence of Level II-C Behavior in Various Cultural Samples

Summaries of research findings involving Level II behavior are located in the pertinent clinical chapters to follow. To familiarize the reader with some of the general meaning of conscious descriptions of self and others the percentage of Level II types occurring in several symptomatic samples will now be presented in Table 3.

TABLE 3

PERCENTAGE OF DIAGNOSTIC TYPES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Percentage of Cases Diagnosed as

Institutional or Symptomatic Sample	*N*	Managerial-Autocratic *AP*	Competitive-Narcissistic *BC*	Aggressive-Sadistic *DE*	Rebellious-Distrustful *FG*	Self-Effacing-Masochistic *HI*	Docile-Dependent *JK*	Cooperative-Overconventional *LM*	Responsible-Hypernormal *NO*	*Total*
Psychiatric Clinic Admissions	207	12	10	18	10	9	11	15	15	100
Hospitalized Psychotic Patients (Male)	46	17	11	11	11	6	20	9	15	100
Group Psychotherapy Patients	101	12	7	11	20	14	11	10	16	101
Individual Psychotherapy Patients	38	8	11	8	5	21	18	18	11	100
Overtly Neurotic Dermatitis Patients	31	10	16	10	13	16	3	19	13	100
Self-Inflicted Dermatitis Patients	56	13	9	14	9	7	13	14	21	100
Unanxious Dermatitis Patients	70	11	11	11	6	4	3	20	33	99
Medical Control Patients	41	7	10	17	7	5	5	22	27	100
Ulcer Patients	42	33	14	24	7	3	3	3	14	101
Hypertensive Patients	49	33	12	4	0	0	6	12	33	100
Middle Class Obese Patients (Female)	100	32	12	4	0	3	2	11	36	100
Total	781									

It will be noted that in their self-diagnosis individual psychotherapy patients emphasize passivity (*HI*), group therapy patients distrust (*FG*), ulcer patients aggressiveness (*DE*), hypertensive and obese patients hypernormal strength (*AP* and *NO*).

Tests of significance among these samples and a detailed discussion of the implications of these findings will be presented in Chapter 24.

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9

The Level of Private Perception: The Interpersonal Symbol

The third level of personality—Level III—comprises the expressions that an individual makes, not directly about his real self in his real world, but indirectly about an imagined self in his preconscious or symbolic world. The interpersonal motives and actions attributed to the figures who people his fantasies, his creative expressions, his wishes, his dreams define the subject matter for this level of personality. They are called preconscious symbolic expressions because they stand for or symbolize aspects of the subject (and his world) which are not directly denoted. The subject selects and employs themes. But he attributes them not to himself or to his real world, but in an imaginary context. They do have a relationship—although indirect and often unwitting—to his conscious and communicative behavior. They have an expressive function, not direct, but symbolic.

The use of the term *preconscious* to describe Level III expressions is a debatable procedure. The preconscious as defined operationally in this volume cannot be equated with the term as used by psychoanalysts. Kris (6, p. 542) has cited two quotations from Freud which define the preconscious. "In defining the quality of the preconscious, Freud follows Breuer: preconscious is what is 'capable of becoming conscious,' and he adds, 'capable of becoming conscious easily and under conditions which frequently arise.' " It might seem, at first glance, that the symbolic and projective responses which define Level III might meet Freud's definition. The empirical situation is, unhappily, not that simple. In actuality subjects do not always express in response to projective stimuli their private or fantasy thoughts. Many defensive, suppressive, rigid patients repeat in their response to projective stimuli the same themes they report in their conscious descriptions. What we get at Level III is, therefore, not preconscious ma-

terial, but those themes which the subject is willing to express in the testing situation. Level III is defined by the source of the data. Level III behavior should, therefore, be accurately labeled as the "response to projective stimuli." This may not be indirect or symbolic or preconscious. Since there is no single term in the English language for denoting "that which the subject chooses to express in reaction to projective stimuli," I have hesitantly employed the familiar terms "symbolic, imaginative, indirect, fantasy, projective and preconscious" as synonyms for Level III behavior. To remind the reader that the psychoanalytic concept is not denoted, the word *preconscious* will be consistently in quotes.

Whenever the subject shifts the content of expression from the actuality—believed, perceived, described—to the imagined, fantasied, then he is communicating in the symbolic mode. In practice this distinction is quite simple and straightforward. The content of dreams, fantasies, creative expressions, wishes, projective tests, automatically becomes Level III data.

The Paradox of Symbolic Life

The phenomenon of symbolization is one of the most puzzling aspects of human behavior. In the first place it seems to be a universal phenomenon. The dream, that obscure, enigmatic ripple across the surface of rational life, is shared by the most literate and the most primitive mind. Rituals, legends, myths, fantasies are woven into the histories of all people and all cultures.

A second paradoxical quality of symbols is their function. Why do all men channel so much energy into symbolization? Man's response to the physical elements is fairly well rationalized. We can explain the cognitive aspects of behavior—the communicative functions of sign, gesture, words in the pattern of social survival has been extensively studied. While the theories disagree in detail, the general purpose of representative signs, whether cries of alarm or notational ciphers, is an explicable area of knowledge. Genetic and evolutionary theories have had considerable success in explaining the survival value of these communications. The discursive language of factual description, which we have discussed in the last chapter, is the most elaborated and practical aspect of human intellectual life. The essence of this form of expression is that it refers to events and things in the objective world. This is called the representational function.

The symbolic function is, however, quite a different phenomenon. It does not refer to the world as it is seen by others. It does not necessarily rely on the lawful principles that regulate the events of reality. Miraculous, magical processes can transpire in fantasies. The limits of

space and time do not apply in dreams. The unreal quality of symbolic productions, which for some philosophers is its outstanding characteristic, certainly assigns them a different function in the economy of human life. The imaginative mode is of little direct use in dealing immediately with the practical aspects of life. Thus, as Langer points out, creative-autistic expressions cannot be explained in terms of their survival value in dealing with the real world. In many cases man's myths and fantastic autisms have confused and hampered his adjustment to the environment around him (7).

The most persuasive solution to this paradox is that symbolic expression is not a response by which man deals with the challenging stimuli of the external environment; it is a response to internal ambiguity and tension.

Reversal Theory of Symbols

In Chapter 7 when we discussed the level of public communication, considerable emphasis was placed on the reflex tendency to select certain interpersonal responses and to avoid others. The phenomenon of reciprocal interpersonal relations formalized this automatic process by which we pull certain reactions from others and, in turn, respond with a limited set of behaviors. The stable continuity that thus develops results in an imbalance. Certain interpersonal techniques for minimizing anxiety are automatically employed. Others which cause anxiety are less favored.

In Jungian terms, certain interpersonal functions are overdeveloped; others are neglected. One side of the circle is predominant, the other inhibited. An imbalance at one level of personality can have many possible relationships to the rest of the character structure. The simplest and most classic case is the reversal concept *repression of the opposite.* Here symbols are held to express the exact opposite of overt or conscious behavior. This is an appealing solution of the conscious-unconscious problem and has by far the most common sense appeal. According to this version, something like a conservation of energy process is at work. The themes which are inhibited and denied from overt manifestation are held to be expressed in symbolic life. Almost every theorist who has written on the psychology of symbolism has leaned on this notion. Much anecdotal evidence supports it. The private life of Walter Mitty is shot through with the acclaim, success, and mastery which he does not express in his prosaic life.

Objections to the Reversal Theory of Symbols

The general popularity of the *reversal* theory of symbolism has not been diminished by the two demurrers that can be raised against it. In

the first place, there are many cases in which it just does not work—the nightmare dream, to take the extreme example, in which the pain of reality is repeated again and again in exaggerated form. A second restraint on the easy acceptance of this theory is that it has never had objective assessment. The *repression of the opposite* theory has never been put to the test because such testing requires a systematic method for measuring behavior at the conscious and overt levels, for measuring behavior at the symbolic level in terms of the same variable continuum, and for relating the different levels.

The Kaiser Foundation Psychology Research Group has attempted to test this reversal hypothesis in a series of correlational studies. This research suggests that the tendency for symbols to express the opposite of conscious or public behavior is not universal or inevitable. It holds for about half of our cases, some of the time. Some persons do tend to employ symbols which are the opposite of their conscious and public imbalances, but others tend to report monotonously in their symbols the same themes which characterize their behavior at other levels. Thus, the reversal or equilibrium theory of fantasy is not a general finding. It varies from person to person. *This variability*, the tendency to use symbols which are the same or different from consciousness, is a measurable, stable, psychological variable. In Chapter 13 it will be defined and validated as a separate and vital dimension of personality in its own right.

Symbols Are Important in Relationship to Other Levels

The fallacy behind oversimplified hypotheses such as the *reversal of symbols* theory is that they focus on a single level of personality—at best, two levels—and attempt to generalize laws. The results are bound to be disappointing and misleading.

We approach the indirect imaginative productions of the human being not expecting them to serve any single function. Any level takes on its full meaning only in relationship to all the other levels, that is, to the total personality organization. This is the organismic assumption. Every level or area of personality is in dynamic equilibrium with all the other levels and the total intricate system of balance and counterbalance makes up the fabulous complexity we call personality. To prevent this organismic assumption from becoming a truism, the syntactical procedures determining the exact number of the interlevel relationships must be made explicit, then the connection between Level III and the other levels of personality can be defined, measured, validated, and understood. The permutations and combinations of levels according to the present notational system will be presented in Chapter 13.

Some Misconceptions About Projective Tests

These findings carry along in their wake some implications for the projective testing movement. This branch of clinical psychology concerns itself with responses to stimulus items which are unstructured or semistructured. The subject is given vague or incomplete test cards and asked to give his interpretation of them. In the Rorschach test he tells what he "sees" in vague inkblot shapes; in the Thematic Apperception Test (TAT) he tells stories which he believes fit and complete the actions portrayed in magazine-type illustrations. The essence of the technique is that the stimuli are ambiguous to some degree and the patient "projects" his own imaginative perceptions. He attributed his own fantasy themes. The theory claims that through his symbols the subject shall be known. The themes elicited are believed to reflect a "deeper" and more valid picture of his personality than those of conscious report.

The field of projective testing is a theoretical shambles. In the first place, interpersonal, Freudian, Jungian, and stimulus-bound variables are jumbled together. The diagnosis is often made in a rag-tail manner, stressing whatever variables happen to drift into focus in the patient's responses or in the clinician's observations. There is rarely any attempt to separate levels. For these reasons, most of the objective assessments of projective test practices have come up with negative findings. Almost every time that independent researchers have tested the hypotheses and predictions involved in projective testing to see if they really work, the answer is "no." It can be flatly said that the field of projective testing, whatever its popularity, is an unvalidated or unsatisfactorily validated enterprise.

The great potential value of this approach to the symbolic has born little fruit because the systematic conceptualization of levels and variables of personality has not been employed. Consider, for example, the patient who produces fantasy materials which are saturated with themes of bitterness and murderous anger. What can we say about the person on the basis of these data? Not very much. We know that his symbols are hostile, but without knowledge of the other levels, our predictions are very limited. If this subject consciously describes himself as loving-agreeable, the symbolic rage takes on one significance. If the bitterness assigned to his fantasy heroes is also attributed to himself at Level II, quite a different interpretation results.

Formal, Noninterpersonal Aspects of Projective Tests

In addition to the content, another aspect of projective tests refers to the so-called formal qualities. Here the clinician studies not the themes but the expressive and stylistic factors of the subject's response.

The impulsivity, constriction, obsessive deliberation, flexibility, carelessness of the performance are observed and measured. They are then indicated in the diagnostic report as characteristic traits.

These behaviors comprise a valid and important aspect of personality. They are noninterpersonal, i.e., they refer to symptomatic, stylistic mood factors. They shift us into a dimension of personality which is distinct from (although lawfully related to) interpersonal behavior. Two critical comments appear to be appropriate in considering these noninterpersonal variables. They are an important part of diagnostic procedure. However, they take on increased meaning to the extent that they are systematically related to interpersonal variables. No test report is complete which summarizes the noninterpersonal style and mood aspects of behavior and fails to include interpersonal prediction. Noninterpersonal variables like any other personality measurements have meaning only in relationship to the total multilevel pattern of purposive behavior. The statement: "The patient acts depressed, immobilized, and constricted on the Rorschach" is a good diagnostic beginning, but it takes on considerably more meaning when we fit it into the broader purposive context, "His immobilized sadness is accompanied by self-descriptions of weakness and helplessness (Level II) and by dependent pressure directed toward the clinician (Level I), etc., etc."

The symptomatic, diagnostic conditions which are not directly interpersonal have been traditionally the central concern of descriptive or medically oriented psychiatry. The Kraepelinian clinician is especially interested in the peripheral area of mood (depressed, agitated, manic) or style of expression (bizarre, obsessive, disorganized, impulsive). The more physiological-neurological the psychiatrist's approach, the more you may be sure that he will avoid interpersonal terminology and depend on the peripheral-symptomatic. In shifting the emphasis to the social dimensions of personality, we by no means neglect the noninterpersonal. We make the hypothesis that the expressive and mood variables of personality have a basic, although indirect meaning. As we shall see, they are related significantly to interpersonal factors at different levels of personality. The symptomatic aspects of psychiatry thus take on an interpersonal meaning. They are related to interpersonal purposes. They predict interpersonal behavior.

A second comment can be made in regard to the noninterpersonal variables tapped by some projective tests. It should be, but rarely is, kept clear that these reactions have little or nothing to do with the symbolic mode. They comprise an entirely separate dimension of behavior. Certain expressive noninterpersonal factors are related to specific interpersonal themes (e.g., energeticness is related to assertive-

ness), but two discrete dimensions of measurement are involved. Now the *content* of imaginative expressions—the themes and purposive motifs—comprise the language of symbolism which we study as Level III data. The *manner* in which the subject deals with the symbolic stimulus materials—lethargically, constrictedly, unhappily—define another level and dimension of personality. The subject can produce a fantasy story in which the themes involve dashing, daring, careless impulsivity; but the way in which he narrates his story can be deliberate, plodding, and painstaking. The theme of the story can be quite different from the way in which it is told. In this case, the interpersonal content of imaginative expressions is assigned to Level III while ratings of the manner and style of expression are assigned to Level I in the noninterpersonal dimension, since they are actions observed and judged by others.

Confusion and vagueness about levels, failure to define them, and neglect of logical systematization has led to this strange situation: many projective tests are employed to tap and study not the symbolic mode, but the motor, perceptual response of the subject. The exceedingly popular Rorschach test stands out as the classic example in this regard. The standard text on Rorschach analysis devotes over seventy per cent of its interpretative attention to variables that have nothing to do with the symbolic mode. The subject's perceptual, executive, organizational techniques, the freedom or constriction of his "affect," the accuracy or deviation of his perceptions and similar topics carry the interpretative burden. The nature and meaning of the symbolic language—the content of the responses—has generally been the stepchild of Rorschach-type theory.

The importance of the perceptual and motor executive aspects of behavior should, emphatically, not be minimized. To measure these Level I noninterpersonal variables many straightforward testing techniques suggest themselves. Experimental psychology and aptitude testing procedures give any number of techniques for assessing impulsivity, organizational synthesizing abilities, perceptual and intellectual functioning. All of these techniques are free from the exhaustive stimulus-bound complexity of the Rorschach. They are also free from the crystal ball, medicine-man aura of the ink blot procedure, which often lends a mysterious and untherapeutic tone to the clinical contact.

To measure symbolic behavior it is necessary to focus on the thematic aspect of the imaginative production. The diminishing popularity of the Rorschach and the increasing trend toward content analysis in projective tests are, from this standpoint, healthy developments.

Formal Versus Thematic Interpretation of Symbols

This distinction between form of expression and content of expression has been made by most psychologists who have concerned themselves with thematic tests. (11) The syntax of levels sharpens this division and takes the important step of assigning the two behaviors to two different dimensions and levels of personality. The logical classification which results has further implications in the broader field of artistic interpretation. Whenever psychologists venture to apply their theories to the aesthetic and creative realm they should, and usually do, make it clear that their analyses refer not to the form but to the content of the artistic production. Psychologists have made many brilliant expositions of the thematic *meaning* of creative expression, but they have properly said little as to the artistic or *formal merit.* They attempt to understand *what* the artist is communicating and not *how* skillfully he is expressing it.

The logic of levels makes this distinction quite clear. Our judgments of the form, the style, the manner of behavior is a Level I operation. We are rating noninterpersonal behavior. Our judgments as to the meaning and thematic message being communicated is a Level III operation. We are rating symbolic expression.

The Function of Symbols

In the last few pages we have been circling around the general question of the meaning of symbolic activity. Symbols are not necessarily the reverse of the coin of consciousness as the theory of opposites would lead us to believe. Nor are they always the behaviors tapped by the so-called projective tests. We shall now consider some answers to the questions: "What is the function, meaning, and purpose of symbols, and what is their practical clinical use?"

Symbols Are a Private "Preconscious" Language. First, it can be said that imaginative expressions are a form of communication, an indirect form. The individual does not tell us directly about himself; he describes a fantasy or unreal set of events. Symbols are the vocabulary of a private language. When the subject talks directly about himself (in Level II) he is describing himself to another person. He is telling the psychiatrist, the tester, or the other patients in his group about his perceptions of self and world. When he talks in the symbolic language of dream or fantasy he is not telling others about himself or his real world. He may be, in a sense, talking to himself. Symbolic language is inexplicable and mysterious if we try to interpret it as though the person were talking directly and openly about his con-

scious perceptions. When interpreted as private language, we see that it can be understood only in the context of its personal meaning to the subject.

It is very well known that all individuals have a set of private perceptions, private opinions, and private reactions which often contrast with the statements of conscious report. This has classically been the despair of philosophers who have had to concede that we can never know exactly what goes on in the mind of another human being. It has made the topic of "consciousness" the source of unending speculative frustration. The first step in approaching this riddle is to accept the inevitable limitations and indeterminacy involved. The second step is to develop the best means for getting as close as possible to the "preconscious" or private world of our fellow men. At the present time, this can be best accomplished through the language of symbolism.

This is by no means a simple or unambiguous procedure. In many cases the subject is made quite anxious if he attempts to translate his own private expressions into the language of direct conscious description. In many cases he is made even more anxious at the prospect of others approaching his idiom. The expression and interpretation of symbols is loaded with complicating qualifications. Their meaning always depends on the dynamics of the total personality and of the context in which the symbols are expressed. Thus the level of personality which includes imaginative indirect communications offers, on the one hand, the most promising avenue to the private world of the subject, and involves, on the other hand, the most ambiguity and interpretive uncertainty.

Symbols Reduce Anxiety. Next we must consider the function of symbolic behavior. Why do human beings develop private languages? The first answer to this question seems to follow quite logically; they develop indirect behaviors to avoid the anxiety of the direct. They express certain themes privately to avoid the anxiety that public expression would entail.

We have seen in earlier chapters that all individuals develop automatic interpersonal response preferences. They use some favored reactions and avoid others which would involve greater anxiety. By means of the language of symbolism it is possible to express interpersonal themes that are inhibited from direct expression. We are returning here to the old principle of expression of the opposite which, we have learned from the data, works only part of the time. We must complete the explanation by adding the other end of the continuum: by means of the language of symbolism it is also possible to repeat and thus strengthen the same themes that are manifested in direct expres-

sion and to avoid further the themes that are inhibited from direct expression. The purpose of symbolic behavior is to reduce anxiety. For some individuals this is accomplished by employing fantasy as a safety valve, an opportunity to "blow off" the interpersonal steam that has built up through inhibitions and repressions. For others, even indirect, imaginative expression of the inhibited themes is anxiety-laden. Symbolic behavior in these cases becomes a way of strengthening the avoidance maneuvers.

Symbolic Mode Indicates the Source and Amount of Anxiety. Thus we see that there is no simple, one-way explanation for the meaning of symbolic language that works for all cases. We lose the comforting simplicity of a generalized rule. But we gain, instead, a new illuminating hypothesis: symbolic language can serve as an index as to the amount and source of the subject's anxiety. The patient who rigidly limits his direct interpersonal activity at Level I to a few narrowed responses and avoids all others can go on to develop any number of symbolic resolutions. If the rigid limitation continues in his imaginative productions then we can assume that the anxiety which cripples and inhibits the absent interpersonal themes is so intense that he cannot express them even indirectly in the private language of symbols.[1] If, on the contrary, the themes which are avoided in conscious report or public communication appear at the level of private conversation, we can make the hypothesis that the anxiety is less crippling and that increased flexibility, mobility, and potential for change exist. And we have, further, a clue as to the direction of the anticipated change, as indicated by the new themes that appear in the private language of symbols. These hypotheses bear up under the objective test (see Appendix 3).

Symbols Can Express Underlying Feelings of Uniqueness and Self-Consolation. We interpret Level III productions in the light of the total personality. It is obvious that symbols can present the same thematic picture as the other levels, they can be "more so," or they can be different. If the latter is true, then the individual has expressed in fantasy the themes he has inhibited in public communications. He may say publicly, "I am meek and weak and suffering." Now he may add the private comment, "but I am also concerned with the theme of retaliation, or power, or prestige." To present this illustration in other words, the individual is saying: "I tell you openly that I am submissive,

[1] The cultural situation in which the symbols are expressed is a crucial factor. Powelson and Bendix (9) have described the effect that a punitive, custodial environment can have on patients' behavior. The cultural context must be added as a qualifying variable to all the generalizations made in this chapter.

but I wish, or hope, or symbolically perceive myself to be strong and powerful." Self-esteem is increased and anxiety diminished by the secret fantasy of fearful power.

This kind of self-punitive masochist in fantasy asserts himself and retaliates against his tormenters. This is a familiar tune. It illustrates the notion of reversal. We have designated this as an *interlevel conflict*—masochism at Level II opposed to sadistic assertion at Level III. But how about the masochist whose fantasy productions are saturated with even more self-defeat? How is this explained in terms of warded off anxiety and the theory of stabilization? These persons—and there are many of them—are convinced at all levels of expression that suffering and self-abasement is the safest, least threatening method of adjustment. They are, we assume, less anxious when they express masochistic themes. They appear to get some consolation, excuse, and poignant merit from unhappy fantasies.

These patients seem to be saying something like this: "I am overtly meek, weak and suffering . . . and covertly I do not perceive myself as anything different." Often the pessimistic corollary is: "I dare not change or I do not wish to change." Patients may enhance their esteem and feelings of uniqueness by means of their private symbols: "No one is as uniquely unloved, helpless, and martyred as I am."

The conceptualization of masochistic behavior is traditionally the proving ground on which personality theories meet their most taxing tests. It is the point where the logical assumptions based on survival value begin to buckle and where new concepts, such as death instincts, are classically dragged into action. We have attempted in the last few pages to employ a motivating principle—avoidance of anxiety and preservation of self-esteem—to explain symbolic activity in the same terms as public behavior.

Time-Binding Nature of Symbols. With these remarks as preliminary it is now possible to present the essential point of this chapter. *Symbolic, indirect or "preconscious" activities are necessary for the human being because he is a time-binding individual.*

Unlike most other mammals, the human being continually faces and deals with conflictful situations in which anxiety threatens in at least two directions. The interpersonal world he has created pushes him toward one set (and often an imbalanced set) of anxiety reducing behaviors. The pressures toward flexibility, both cultural and personal, may push him toward another source of self-esteem. The individual's overt behavior does not express the impulse or desire which he feels.

This point has been well made by Murray and Kluckhohn (5 p. 18). They point out that: ". . . the personality is almost continuously in-

volved in deciding between alternative or conflicting tendencies or elements." Personalities deal with these conflicts by constructing "schedules which permit the execution of as many connotations as possible, one after the other." They go on to say, "Most men are forced by circumstances to make decisions which commit them to schedules arranged by others (e.g., the daily routine of a job); and so a large portion of the temporal order of their days is not of their own shaping. Also, every culture prescribes schedules, general and special, which define the proper time, place or order of certain actions, and, therefore, schedule-making is a sphere in which the individual is likely to come into conflict with his society."

Postponement of impulse is thus an inevitable characteristic of human behavior. The individual is continually inhibiting some actions in favor of others, generally moving in the direction of the lesser anxiety.

This postponement phenomenon is called the time-binding aspect of human behavior. The function of "preconscious" or "unconscious" activities might thus be explained as time-binding. The basic discovery of Freud that unexpressed impulses do not disappear but remain as active, although indirect, elements in the personality can be considered as a temporal rather than a structural phenomenon. The unexpressed motives relate to the past and the future.

From the functional viewpoint, the essence of private or "preconscious" factors is that they are potentials for later overt or at least conscious expression. If they did not have this potentiality then they have little meaning. This time-binding theory of the "preconscious" is important and useful in the interpretation of symbolic behavior.

Whenever we obtain a symbolic, "preconscious" theme from a subject, it suggests that this theme is a potential for future action. The time-binding theory of the "preconscious" places the symbol produced in the present on a temporal dimension pointing (we assume) to earlier frustration and functionally more important to a later expression of the theme.

Symbols Predict Future Behavior. The functional value of symbolic behavior to the clinician can now be stated. The data of Level III are predictions of the future. We have proposed the hypothesis that the patient's symbols tell us, in the case of conflict between conscious and "preconscious" themes: "Here is another side of my interpersonal picture." In the case where the fantasy themes are not discrepant from overt behavior he tells us: "My rigid pattern does not change even in symbols." The "preconscious" themes tell us how likely the person is to change his behavior and in what direction he is

likely to change. The usefulness of this information in clinical practice is obvious.

If this theory is correct, then symbols should indicate the amount of anxiety that operates in any given personality structure, and they should give us an estimation of the amount of change to be expected and the type of change to be expected.

If this theory is correct, a prognostic instrument of considerable importance becomes available to clinicians. And conversely, if the predictions do hold up when applied to clinical practice, a major theoretical step will have been taken in explaining that area of personality which has always been so resistant to explanation. In helping the clinician predict, we shall have validated the theory of symbols.

In order to test this hypothesis, several methodological problems had to be met. It was necessary to convert the loose, diverse language of symbols into scientific categories. The interpersonal variables thus defined must be capable of reliable measurement. They must be directly and systematically related to the other levels of personality so that interlevel conflicts and discrepancies can be measured.

The data for Level III, it will be remembered, are defined automatically by the source from which they come. A dream, a fantasy, or any projective and imaginative expression reported by a subject is assigned to the symbolic mode. The "preconscious" level, like the more overt levels, is divided into two areas: *self* and *other*, or *symbolic hero* and *symbolic world*. This division produces two distinctly different types of Level III material which have unique applications and lawful relationships to other levels of personality.

Six Methods for Measuring Level III Behavior

There are six methods which have been employed by the Kaiser Foundation project for measuring Level III behavior. Whenever the discussion centers on the generic level of "preconscious" expression we used the code Level III. Whenever we refer to specific measurements of "preconscious" behavior it is necessary to indicate the specific source of the data by adding the appropriate code letter. This is accomplished as follows:

When trained personnel rate the interpersonal content of responses from the Iflund projective test (4) the scores are labeled *Level III-i*. Scores for the Blacky projective test (1) are coded *Level III-B*.

When the interpersonal themes for dreams are rated by trained personnel the scores are indicated as *Level III-D*. Themes from waking fantasies are coded *Level III-F*.

MMPI indices which are being developed to predict preconscious behavior are coded *Level III-M*.

When trained personnel rate the interpersonal themes from the Thematic Aperception Test (TAT) the scores are labeled *Level III-T*. The research studies reported in this book employ the TAT as the standard instrument for Level III.

When trained personnel rate the interpersonal themes from the Interpersonal Fantasy Test the scores are coded *Level III-IFT*.[2]

The hypothesis that "preconscious" symbols predict future behavior to be expected at overt or conscious levels has been tested by means of several research studies. The design and detailed results are presented in Appendix 3. These findings do confirm this hypothesis. "Preconscious" behavior does predict the kind and the amount of change to be expected in future overt behavior. If the TAT, for example, is more hostile than the self-diagnosis at the first testing, then the self-diagnosis can be expected to change over time in the direction of greater hostility.

The methodology for measuring symbolic behavior which is used in clinical diagnosis and in these validating research studies will now be presented.

The Measurement of Interpersonal Symbols

The raw data of Level III comprise the verbal language of the dream texts, fantasy stories, projective test protocols. The task here is the same as at any other level of personality—to convert the raw protocol language into objective categories. One of the basic principles of the interpersonal system of personality is that the same matrix of variables should be used at every level of behavior. This facilitates direct comparison between levels.

This principle settles in advance the issue of what variables are to be used in measuring symbolic behavior. The sixteen-variable circular continuum by which we rate public communications and conscious descriptions is also employed to analyze the imaginative data.

Classification of Fantasy Materials into "Hero" and "Others"

We rate the heroes and protagonists of the fantasy world just the way we rate the activity of the subject's *real self* and *real world* at Levels II and III. If the dream hero is fearful, he is scored *H*; if he is murderously enraged, we score *E*, etc. The same procedure of differentiating between the *self* and the *other* is preserved. The hero of the

[2] The Interpersonal Fantasy Test is a projective instrument developed to tap the subject's fantasy descriptions of the permutations and combinations of the most standard and crucial interpersonal relationships. It is tailored to the interpersonal system just as the Interpersonal Check List is designed to tap the sixteen variable continuum. The Interpersonal Fantasy Test is published by the Psychological Consultation Service, Berkeley, California.

dream becomes the *symbolic self*. The people he interacts with denote the interpersonal other. The identities of these figures of the interpersonal world are specified much as they are at Levels I and II. Formal rules and conventions for determining which character in a dream or fantasy story is the hero and which are the "others" have been developed. (See Appendix 3.)

This division into "preconscious" hero and "preconscious" other is an important one. It defines two separate sublevels of the "preconscious." Studies taken from several widely differing samples consistently show that the "preconscious" other scores are significantly different from the "preconscious" self or hero scores.

The establishment of an operationally defined hierarchy of "preconscious" layers has functional value. It helps us understand the amount of anxiety connected to any interpersonal behavior. If an emotion—let us say, rebelliousness—appears at Level II, we can assume that the subject is not made so anxious by the emotion that he must avoid it consciously. He can tolerate this interpersonal behavior in conscious report. If he completely avoids or denies it at Levels I and II, one assumes its direct expression makes him anxious.

If, in this latter case, the rebelliousness appears at Level III hero, this indicates that he can tolerate the emotion at the "top layer of fantasy." This indicates that the anxiety connected with unconventional behavior is not too massive or crippling.

Let us consider the case where rebelliousness is completely avoided at Levels I, II, and Level III hero. This suggests that the three most overt levels are organized against the expression of the emotion. Considerable anxiety must be connected with its expression.

At this point the distinction between Level III hero and other becomes functionally useful. Since there is evidence that Level III other is deeper than Level III hero, we look to the themes attributed to the fantasy world. If they, too, are marked by an avoidance of rebelliousness, we have an added cue as to the amount of anxiety attached. If the themes warded off at the three more overt layers finally appear in the fantasy world, then they become potentially available for future integration into awareness.

This brings us, of course, to a classic item of clinical folklore—it is easier for the patient to master and integrate feelings which are projected onto others than if they do not appear at all. *Pulling back* projections and accepting them into the self-structure is a basic therapeutic procedure. The differentiation of layers of "preconscious" behavior is a useful device with considerable clinical application. Preconscious themes attributed to fantasy others are thus considered part of the subject's personality, usually related meaningfully to the conscious or preconscious self.

Classification of Fantasy Images

There is a further differentiation of "preconscious" behavior which has certain theoretical and clinical implications. The fantasy stories are first divided into self or hero and the themes attributed to each are scored according to interpersonal variables (see next section). After the main hero-world themes are scored, then each character is classified according to his familial status. The categories employed are maternal figures, paternal figures, cross-sex figures, and same-sex figures. It is then possible to add up the scores which summarize the relationship between:

Male child vs. Maternal figure
Male child vs. Paternal figure
Female child vs. Maternal figure
Female child vs. Paternal figure
Fantasy figures of subject's sex vs. Cross-sex figure
Fantasy figures of subject's sex vs. Same-sex figure

These procedures give a summary of the interpersonal behavior assigned to these important role relationships at the level of fantasy. In a later chapter we shall consider indices which systematically link these interlevel processes, e.g., the similarity or difference between the conscious and "preconscious" views of maternal figures. The classification of "preconscious" personages make possible the operational definition of such processes as displacement, "preconscious" identification, and the like.

Symbols Involve Greater Violence and Intensity

There is a difference between the rating of Level III themes and overt behavior. The actions and traits expressed in the symbolic mode are usually much richer than those of the other levels. More intensity of feeling and violence of action occurs. Patients rarely describe murders or world-shaking power motives in their conscious reports about their real lives. In their Level I observed interactions in group therapy, the patients may insult or help each other—but blood never flows. The acts of generosity are limited and generally expressed verbally.

This is, of course, not so in fantasy. Intense affect, crime, rape, suicidal grief, physical and material generosity, bodily exchanges of love and hate often occur. The same interpersonal motives appear to underlie the interactions of both levels. The sixteen-variable continuum seems adequate to categorize the behavior. It is the manner in which the interpersonal purpose is expressed that is different.

For this reason additions to the rating system have been made in order to handle symbolic data. The list of specific ways in which the same interpersonal purposes can be manifested must be expanded. In a therapy group or discussion group the motive *D* can be expressed through sarcasm, disapproval, punitive comments, derision, verbal threats, etc. In fantasy the motive *D* can be expressed in these same terms, but in addition in a more intense manner. These generally involve physical or material modes, brutal punishments, actual destruction, incarceration, execution, etc.

The illustrative key employed in analyzing symbolic activity, therefore, includes all the actions measured at Levels II and I—but it also includes the more intense and violent activities of the fantasy world.

The Variables of Level III

Table 4 presents a list of sample behaviors as rated at Level III. It must be kept in mind the list of verbs used at Level I and the list of attributes used at Level II also apply in the symbolic mode. We have not duplicated these lists of behaviors here, but have listed just the interpersonal events which are unique to Level III.

TABLE 4

ILLUSTRATIVE CLASSIFICATION OF INTERPERSONAL BEHAVIOR AT THE SYMBOLIC OR PROJECTIVE LEVEL

A. The code *A* is assigned to themes of *Power*: Leadership, Command, Direction, Authority.
B. The code *B* is assigned to themes of *Narcissism*: Independence, Self-Expression, Superior, Power Struggle.
C. The code *C* is assigned to themes of *Exploitation*: Seduction, Rape, Rejecting, Depriving, Selfishness, Keeping Away From, Keeping Children to Self.
D. The code *D* is assigned to themes of *Punitive Hostility*: Punishment, Coercion, Brutality, Quarreling, Threat.
E. The code *E* is assigned to themes of *All Forms of Pure Hostility:* Disaffiliation, Murder, Anger, Fighting.
F. The code *F* is assigned to themes of *Unconventional Activity*: Passive Resistance, Rebellion, Generic Crime versus Authority, Pure Jealousy, Drunkenness, Stealing Covertly, Offended, Bitterness.
G. The code *G* is assigned to themes of *Deprivation:* Distrust, Disappointment, Rejectedness, Suspicion, Bad Things Are Done to One.
H. The code *H* is assigned to themes of *Masochism*: Grief, Suicide, Withdrawal, Guilt, Provoking Punishment, Self-Punishment, Fear, Anxiety, Insanity (Unspecified), Loneliness, Running Away.
I. The code *I* is assigned to themes of *Weakness*: Obedience, Submission, Unconsciousness, Indecision, Ambivalence, Immobilization, Illness, Passivity.
J. The code *J* is assigned to themes of *Conformity*: Accepting Advice, Provoking Advice, Being Student, Docility, Followership, Positive Passivity.
K. The code *K* is assigned to themes of *Trust*: Cling, Good Things Come to One, Good Luck, Being Taken Care of, Dependence, Gratitude.
L. The code *L* is assigned to themes of *Collaboration and Agreeability*: Congeniality,

Cooperation, "Generic Happy Ending" Caused by People Working Things Out, Adjustment in General.

M. The code *M* is assigned to themes of *All Forms of Pure Love*: Affiliation, Marriage, Friendship.

N. The code *N* is assigned to themes of *Tenderness*: Support, Kindness, Encouragement, Solace, Pity.

O. The code *O* is assigned to themes of *Generosity*: Help, Curing Someone, Taking Care of Someone, Giving.

P. The code *P* is assigned to themes of *Success*: Heroism, Popularity, Acclaim, Achievement, Wisdom, Teaching, Explaining.

The cautionary statements made when we listed sample themes for Levels I and II must be repeated again. This table of themes is illustrative. Actually the list of potential symbolic themes is exhausted only by the seemingly infinite variety of man's autism and creativity. We have included here only the most common. (A glance at Table 4 makes apparent the great variety of behavior tapped in the symbolic mode. Any aspect of human experience can appear at Level III: sexual events, relations to authority, law, nature, occupational and political adjustments, the vicissitudes of childhood, mating, marriage, parenthood, of growing up and growing old.) The illustrative words in Table 4 tap only a small fraction of the potential. We have concentrated, therefore, on the events most commonly obtained in response to a standard projective test—the Thematic Apperception Test.

In actual practice the rating is assigned not in a routine, check-off fashion, but by a judgmental application of the circular concept. That is, the list of themes presented in this illustrative figure is not applied automatically. *Murder* can be scored as *F*, *E*, or *D* depending on the power element involved in the hostility. Success is *B* if it involves superiority or proving someone else inferior; it can be *P* if it involves the notion of respect or admiration from others.

Here are examples of the interpersonal system applied to three varieties of Level III data: a dream of Sigmund Freud (Level III-D), a fantasy (Level III-F), and a projective test story (Level III-T).

The Scoring of Interpersonal Symbols from a Dream of Sigmund Freud

Freud in *The Interpretation of Dreams* (2, pp. 195–96) presents a protocol which can be used to illustrate the scoring of interpersonal symbols. This dream concerns "preconscious" transference-countertransference feelings on the part of Freud and provides an example of how Level III self and other scores are employed to yield different measurements.

Freud prefaces this dream with the explanation that Irma was a patient whose analysis ended only "in partial success." "I expected her

to accept a solution which did not seem acceptable to her." Later a friend reported to Freud that Irma "was not quite well." Freud reports he was annoyed by the possible reproach in the friend's voice "that same evening I wrote the clinical history of Irma's case, in order to give it, as though to justify myself. . . ."

These Level II conscious descriptions of Freud would be scored as follows:

Protocol Description	*Self*	*Other*
"I expected her to accept a solution which did not seem acceptable to her."	*A* or *B*	
		F
A friend reproaches Freud.		*D*
This "annoyed me."	*E*	
The patient's relatives did not approve of the treatment.		*D*
Freud tries to justify himself.	*B*	

The relationship between Freud and the patient is summarized as:

$$\text{Freud} = A \text{ or } B \longleftrightarrow \text{Patient} = F$$

The relationship between Freud and the friend and relatives of the patient is:

$$\text{Freud} = E \text{ and } B \longleftrightarrow \text{Friend} = D$$

Freud's conscious description of self in this episode locates in the upper left-hand quadrant of the interpersonal circle. He is strong, right, and righteously angry.

The night following these events Freud had a dream. We shall consider the first section of the dream which relates to the relationship to the patient.

Dream of July 23–24, 1895	*Freud*	*Patient*
A great hall—a number of guests, whom we are receiving—among them Irma, whom I immediately take aside, as though to answer her letter, and to reproach her for not yet accepting the "solution." I say to her: "If you still have pains, it is really only your own fault."—She answers: "If you only knew what pains I have now in the throat, stomach, and abdomen—I am choked by them." I am startled, and look at her. She looks pale and puffy. I think that after all I must be overlooking some organic affection. I take her to the window and look into her throat. She offers some resistance to this, like a woman who has a set of false teeth. I think, surely, she doesn't need them.	*A—directs* *D—reproaches* *A—directs* *D—is critical*	 *F—complains* *I—acts weak* *F—rebels*

The scoring of this dream indicates that Freud's "preconscious" view of his relationship with this patient is as follows:

Freud's "preconscious" self = Strong, right, punitive
Freud's "preconscious" other = Weak and rebellious

At this point we have data from three layers indicating Freud's reaction to this interpersonal situation. At Level II Freud is strong and self-confident. At the next deeper level of personality, i.e., Level III-D hero, he is strong and righteously angry. At Level III-D other, he attributes to others rebellious and weak themes. This last statement requires comment. We no longer consider Level III other as being a characteristic of the "other one," but as a deeper estimate of the subject's own feelings which have been projected onto "preconscious" images. The Level III other can be seen as an underlying identification with weakness.

A three-layer summary of Freud's reactions to a rather difficult interpersonal situation thus results. We see that at two top levels (Level I is, of course, not available) Freud was maintaining a position of strength, self-confidence, and sternness. At the deeper layer (Level III-other) there is evidence suggesting that Freud felt resentful and threatened by this experience. His rebelliousness and feelings of weakness, we assume, were accompanied by some anxiety because they appear at Level III-D other, projected onto the image of the patient. This anxiety was not crippling as indicated by Freud's frank description of his feelings.

A classic example of fantasy behavior is found in the short story "The Secret Life of Walter Mitty" by James Thurber (10). A summary of his overt behavior is contained in the following episode:

Level I-R Behavior of Walter Mitty as Scored by the Interpersonal System

Self		*Others*
	Walter Mitty stopped the car in front of the building where his wife went to have her hair done. "Remember to get those overshoes while I'm having my hair done," she said. "I don't	*A—directs*
F—passively resists	need overshoes," said Mitty. She put her mirror back into her bag. "We've been all through that," she said, getting out of the car. "You're	*B—patronizes*
	not a young man any longer." He raced the engine a little. "Why don't you wear your	*D—ridicules* *A—directs*
	gloves? Have you lost your gloves?" Walter Mitty reached into a pocket and brought out	*D—accuses*
I—obeys	the gloves. He put them on, but after she had turned and gone into the building and he had	
F—passively resists	driven on to a red light, he took them off again. "Pick it up, brother!" snapped a cop as the	*A—directs*
I—obeys	light changed, and Mitty hastily pulled on his gloves and lurched ahead.[3]	

These interactions are profiled in Figure 15.

[3] "The Secret Life of Walter Mitty." Copyright, 1939, James Thurber. Originally published in *The New Yorker.*

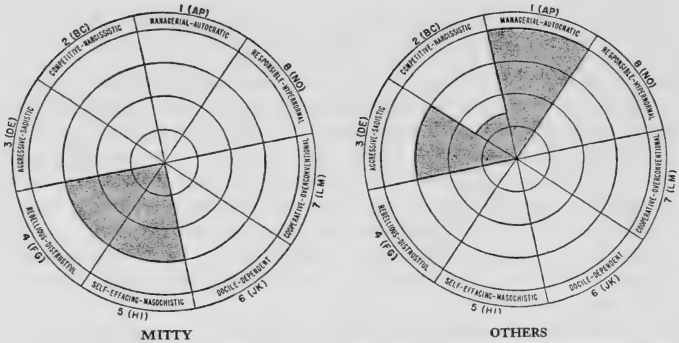


FIGURE 15. Diagrammatic Summary of Walter Mitty Interaction at Level I-R. *Key:* Radius of circle = 4 raw scores.

These profiles indicate that submission and passive resistance characterize Walter Mitty's overt behavior. He provokes bossy, superior, and critical behavior from others.

The underlying feelings of Thurber's hero are, of course, quite different. There are five fantasies included in this story each of which portrays the hero as commanding, successful, proud, disdainful, and deeply respected.

Level III-F of Walter Mitty as Scored by the Interpersonal System (Molecular Rating)

Self		*Others*
A—commands	"We're going through!" The Commander's voice was like thin ice breaking. He wore his full-dress uniform, with the heavily braided white	
B—confidence	cap pulled down rakishly over one cold gray eye. "We can't make it, sir. It's spoiling for a hur-	*F—complain*
D—stern firmness	ricane, if you ask me." "I'm not asking you, Lieutenant Berg," said the Commander. "Throw	
A—commands	on the power lights! Rev her up to 8,500! We're	
B—confidence	going through!" The pounding of the cylinders increased: ta-pocketa-pocketa-pocketa-*pocketa-pocketa.* The Commander stared at the ice form-	
A—commands	ing on the pilot window. He walked over and twisted a row of complicated dials. "Switch on No. 8 auxiliary!" he shouted. "Switch on No. 8	*I—obeys*
A—commands	auxiliary!" repeated Lieutenant Berg. "Full strength in No. 3 turret!" The crew, bending	*I—obeys*
	to their various tasks in the huge, hurtling eight-engined Navy hydroplane, looked at each other and grinned. "The Old Man'll get us through,"	*J—admire*
	they said to one another. "The Old Man ain't afraid of Hell!" . . .[3]	

[3] *Ibid.*

The item by item scoring of each interpersonal action in this fantasy illustrates the molecular system for rating Level III-F behavior. Where several fantasies are available it is often economical to assign a single summary rating to the behavior of the hero and other. This is called *molar* rating. The molar scores for this episode would be:

Mitty	*Others*
AB	*IJ*

This scoring translates into the verbal summary: "The hero is commanding and self-confident; others obey and admire him."

The Scoring of Interpersonal Symbols from the Thematic Apperception Test

In the Thematic Apperception Test (8) the subject is given a series of cards which contain magazine-type illustrations. The task is to tell a story which fits the picture. He is requested to describe the action, the feelings of the characters, and the outcome of the plot.

The following illustrative story was told in response to TAT Card 2-i which pictures a farm scene, a young woman in the foreground holding books, an older woman in the background leaning against a tree, and a man in the distance plowing. A patient told the following story of this picture. The scored themes are italicized:

	Symbolic Self (Hero) Scores	*Symbolic Other Scores*
They probably got up and had breakfast–the Mother and Daughter.		
The daughter looks like she *hates* her Mother.	*E*-3	
I guess because of the Mother's *stern* look.		*D*-2
Her body shows no emotion. I think she'll *run away*	*H*-2	
–but not from the school–because she *resents* her	*F*-3	
Mother who is so *unkind* to her and		*D*-3
doesn't show her any love.		*C*-2
My own feeling tells me she *flees* from the situation.	*H*-3	

It will be noted that every interpersonal feeling or action in this story was given a separate score. This method of rating every interpersonal unit is called *molecular scoring*—every interpersonal detail gets a separate rating. It is possible to add up all the scores given to the hero and to the "other" in this story—or to summarize all of the molecular themes from all the TAT cards.

The scores for this particular story, combined into a Level III-T profile, are shown in Figure 16. This graphically portrays the themes of anger (*E*), resentment (*F*), and retreat (*H*) from a hostile (*D*) and rejecting (*C*) parent.

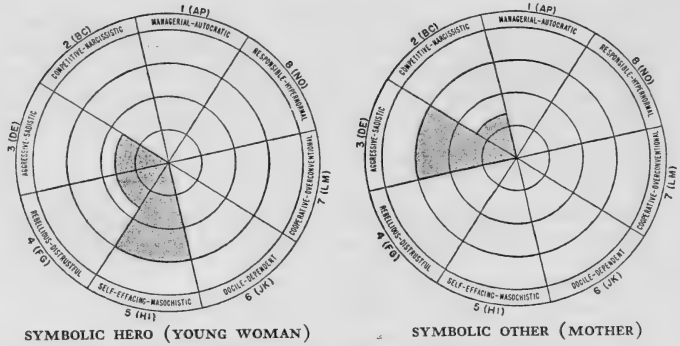


FIGURE 16. Diagrammatic Representation of Interpersonal Scores for an Illustrative TAT Story. *Key:* Radius of octants of circle = 4 scores.

Another method for scoring TAT data which has proved more convenient is to read over the entire story and to assign an over-all score to the basic relationship between hero and other. This is called *summary* or *molar* TAT scoring. For this particular story the molar rating would be:

Hero (Daughter) *Other (Mother)*



This summary formula tells us that the fantasy hero resents and then withdraws from an unsympathetic mother.

Case Summaries Illustrating the Relationship Principle of Symbolic Data

At this point we have just about completed the description of three of the four levels of personality which are now employed by the Kaiser Foundation project. It is now possible to put the data for the three levels together and to work out some tentative formulations about some of the relationships among levels. The following case studies are designed to show that symbolic data are useless when studied in isolation and that they are most useful when studied *in relationship* to other levels of personality.

SYMBOLS OF DISTRUST, DEPRIVATION, AND ISOLATION. As part of the initial evaluation process at the Kaiser Foundation Psychiatric Clinic

patients are given a battery of tests which measure different levels of the interpersonal system. When the tests from each level are scored, the results are fitted together to determine the interpersonal diagnosis and to provide the data for clinical prediction.

Let us consider a subject whose "preconscious" language is loaded with themes of deprivation, distrust, and loneliness. One such patient described all his heroes as failures, unloved, beaten, and exploited. They all ended up suicidal, isolated, frustrated. All his endings were unhappy.

With these data in mind, what predictions can we make about his conscious view of self or his interpersonal reflexes? Many such patients see themselves consciously in the same way. They report their real life as being frustrated, unhappy, isolated. They may describe their interpersonal world as being reciprocally rejecting and disappointing. In Figure 17 we see such a patient. The subject's conscious description matches the discouragement of his symbols. The fantasied others are unsympathetic, much as he describes his own father.

Many other subjects whose symbolic heroes are deprived and isolated show a markedly different pattern at Level II-C. The self descriptions, instead of being weak, isolated, and pessimistic, may emphasize strength and success. A clear conflict exists between the self-perception and the self as symbolized.

The meaning of the fantasy productions varies considerably in these two cases. The passive deprivation means one thing when it duplicates the pessimism of Levels II and I. It means another thing in the context of overt overoptimism and expansiveness. A diagnosis of conflict is defined in the latter case. If this conflicting pattern is confirmed by the other system measurements and by the clinical history, a considerably different prognosis and therapeutic program would result.

Level III takes on meaning in relationship to the other levels of personality.

Conflicting Symbolic Themes of Power and Weakness. The two cases just considered possessed rather narrow symbolic patterns emphasizing the themes *FGHI*. This overloading of symbolic themes in one direction is not unusual—neither is it inevitable. Many patients reflect a more ambivalent picture at the symbolic level. In these cases the fantasy material may indicate the nature of an underlying conflict —but they do not tell us which side of the ambivalence is being expressed at the overt levels. They do not tell which interpersonal reflex pattern is employed.

Let us take as example a patient whose TAT stories were concerned with the themes of strength and weakness. In some of his fantasies the

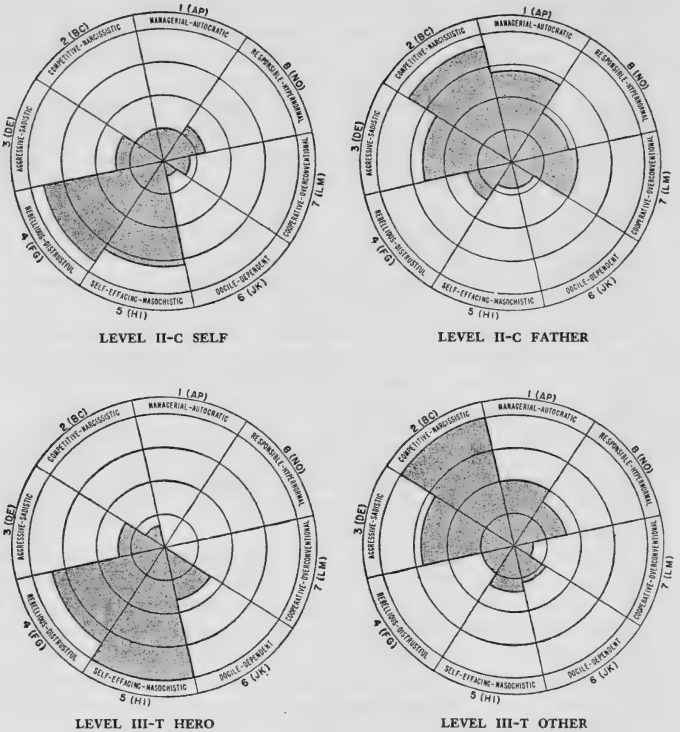


FIGURE 17. Level II-C and Level III-T Hero and Other Profiles for Illustrative Case. *Key:* Radius of Level III-T circles = 8 scores; radius of Level II-C circles = 16 scores. Raw scores are employed in these illustrative diagrams.

heroes were wise and respected figures winning the attention of admiring followers. In other stories the heroes were docile, dependent figures looking up to powerful, esteemed others. All the people described in his imagination were either leading or being led. They diagrammed in Figure 18:

These symbols clearly reveal a preoccupation with strength and weakness. They suggest that a marked ambivalence exists concerning power motives. With this knowledge of the subject's fantasy conflict can we diagnose the other levels of personality? Not very well. We can safely guess that the overt levels of behavior will fall along

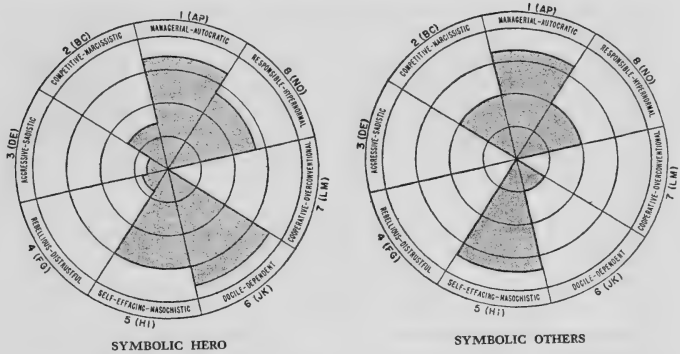


FIGURE 18. Diagrammatic Representation of Symbolic Hero and "Other" Scores Illustrating Conflict Between Power and Weakness. *Key:* Radius of each octant of circle = 8 scores (i.e., raw TAT ratings).

the power-submission axis (*AP* versus *H*, *I*, *J*, *K*). It is statistically unlikely that he will describe himself or present himself as hostile or affectionate. We can thus eliminate roughly one half of the circular continuum (*D*, *E*, *F*, *G* and *N*, *O*, *L*, *M*).

What we cannot do is predict whether he will present himself as strong or weak. His interpersonal reflexes may reflect either aspect of the underlying conflict. They may express both sides. When a conflict between dominance and submission exists at the "preconscious" level, about one half of such cases manifest themselves as strong people denying weakness. Such patients resist psychotherapy, complain of physical rather than emotional symptoms, deny emotional disturbance, depression, or passivity. These patients express one side of their ambivalence—the strong side. They "sit on" the weak aspects. These patients are often called counterphobic or *compensatory* cases. This means that they react against their underlying feelings of weakness by appearing very strong, indeed. Figure 19 shows how one such patient appeared at Levels I-S and II-C.

But many other patients with the same TAT pattern of conflicting strength and weakness appear quite differently at the other levels. They stress the passivity side of the power-passivity axis. They claim to be depressed, immobilized, inferior people. They apply for psychotherapy eagerly. They have strongly developed reflexes of helplessness. They willingly admit their need for treatment. These people are also "sitting on" one side of their underlying conflict—the strong side. The fantasy themes of power and esteem are consciously attrib-

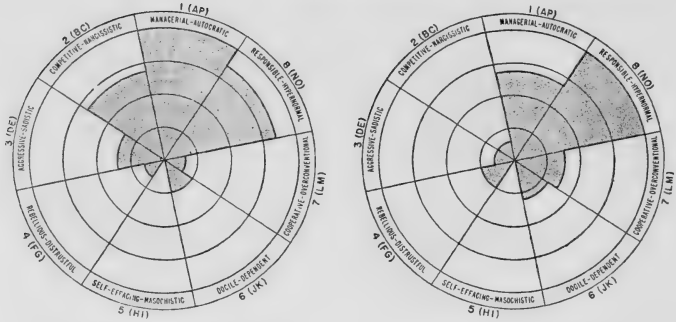


FIGURE 19. Diagrammatic Representation of Level I-S & II-C Self Scores Illustrating a Façade of Power and Responsibility.

uted to others (often the therapist). The strong-dominant side of their fantasy coin which does not overtly appear usually manifests itself in the later sequences of the relationship. Patients who present themselves in this manner are commonly called by several names (usually depending on the specific, peripheral aspects of symptomology). They include the phobics, neurasthenics, anxiety neurotics. Figure 20 shows how a typical case might profile.

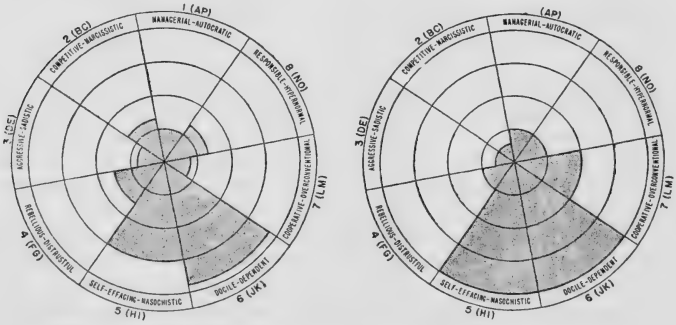


FIGURE 20. Diagrammatic Representation of Level I-S & II-C Self Scores Illustrating a Façade of Weakness and Docility.

Two theoretical points have been developed in this last series of illustrations—one old, the other new. The first is the familiar refrain —the language of symbols does not necessarily duplicate or reverse the other levels of personality structure. In his overt behavior the patient may repeat the symbolic motifs—or he may be counterbalanced away from them. Symbols often predict future change in overt behavior —but their meaning must always be assessed in terms of the total personality structure.

The second point concerns the notion of the *conflict axis.* We have noted that symbols can be the same or they can be different from the levels of reflex action and perception. They can also be mixtures—combining the overt motives with the new themes unique to the symbolic language. In these cases symbolic ambivalence is present. The imaginative themes cluster into two polar areas. One of these is usually stressed overtly and one is not.

When this pattern of scores develops, a conflict is defined. The kind of conflict is determined by the location of the thematic clusters around the circle. The last case presentation illustrated a phobic-counterphobic conflict in which docile weakness covered underlying conflict between strength and weakness.

When a patient's multilevel pattern of scores tends to cluster into two areas in the diagnostic circle we speak of the conflict axis. In the last two illustrations of phobic-counterphobic behavior the conflict axis was *I–A.* Other common dichotomous clusters are *D–H* which defines sado-masochistic conflict; *O–K* denoting nurturance-dependence; *M–E* denoting love-hate, etc. The relation between fantasy heroes and their protagonists often defines such reciprocal clusters. In one story the disappointed hero is rejected by the exploitive lover. In the next story the hero spurns his heartbroken mate to follow his own selfish goals. In the language of the notational system these are expressed as:

1)	*Hero*	*Lover*
	G	*C*
2)	*Hero*	*Mate*
	C	*G*

A conflict of rejecting versus being rejected is thus suggested. The conflict axis is *C–G.* The level of symbolism can help define the conflict axis—the focal centers around which the patient's behavior at overt levels tends to cluster. Symbols can predict basic multilevel conflicts.

Sweet Symbols Behind a Façade of Sweetness. In the last few pages we have used some tentative case illustrations to fit together data

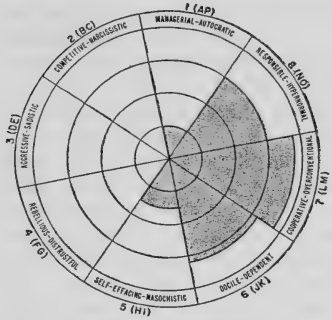
from three levels of personality. These have served to underline some earlier principles and to introduce some new concepts (such as the conflict axis). We turn now to a third type of case which will continue this process of review and preview.

The subject in this case produced fantasies that are models of "sweetness and light." The heroes are affectionate, conventional, and generous. When evil or hatred appears it is met by virtue and agreeability—and usually transformed into good. All the endings are happy. In the case of the TAT even those cards which are loaded with negative stimuli are transferred into positive. One card is seen by most people as portraying a girl slumped beside a gun. The case in question sees this as a girl overcome with joy, the vague gun-like object beside her becomes a "gift" from a loved one which has led to the joyous collapse. Another card which pictures a sprawled-out figure described by most people as dead or wounded is seen by our subject as a "sleeping man exhausted from a day of good work." Figure 21 shows how the symbolic scores might profile.

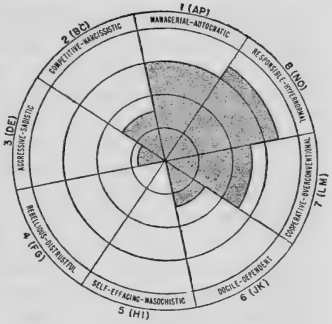
The scores for Level II-C self and father are also included, showing that the *pollyanna* pattern of optimism and goodness appears at the level of conscious description. Now it is quite possible to have *sweet* symbolic themes and hostile self-perceptions. When this occurs we have a conflict between a rough exterior and a symbolic heart of gold. The case profiled in Figure 21 shows no conflict, however. A sweet and loving façade covers sweet and loving symbols.

This means that the subject tells us—in the language of fantasy—the same message that he has expressed in conscious description. He denies hostility at Level II-C and both "layers" of Level III-T. We have assumed that a defensive process leads to extreme avoidance of negative affect in conscious description. The same process spills over into the level of imagination. We call this phenomenon a *rigid invariance*. We conclude that the same anxiety process which imbalanced Level II-C in the direction of socially approved motives is at work at Level III-T. We suspect that hostility and assertive, bitter feelings are so anxiety provoking that they cannot be expressed in the more flexible language of symbolism. They cannot appear in responses to the cards on which the average person reports them. They cannot even be projected onto the fantasy "others." Even if the stimulus picture on the card pulls for hostile themes, this subject can maneuver his perceptions to avoid them. Ravaged corpses become sleeping beauties.

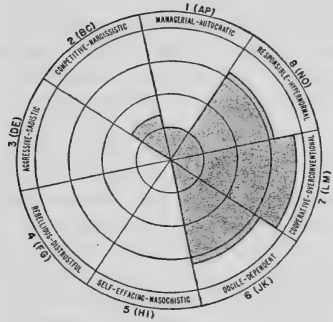
Three points are worth stressing—the first two are familiar and the other is new. The first: fantasy themes give a rough indication of the interpersonal source of anxiety and the amount of it. If the themes



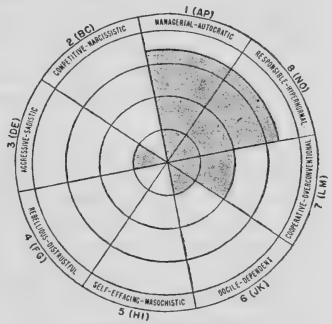
LEVEL II-C CONSCIOUS
VIEW OF SELF



LEVEL II-C CONSCIOUS
VIEW OF FATHER



LEVEL III-T HERO



LEVEL III-T OTHER

FIGURE 21. Level II-C & Level III-T Hero & Other Profiles for a Rigidly Conventional Patient.

that are strictly avoided at Levels I and II are also eschewed at Level III we may speculate that these themes are the source of anxiety for this patient. The consistency of the avoidance at all levels indicates roughly how much anxiety. In the illustrated case we might guess that there is plenty of anxiety connected with the expression of aggression and antisocial motifs.

Symbolic Themes Are Not Always "Preconscious" or Opposed to Consciousness

A second issue illustrated by this case concerns the nature of fantasy expressions. The fact that themes appear in dreams or projective tests

does not mean that they are necessarily different from conscious perceptions. Autistic productions are not an automatic "pipeline" to the underlying motivation. They can simply repeat the pattern of security operations employed at the overt levels.

This point has not been made clear in the psychological literature. There is a common tendency to assume that symbolic or projective data inevitably denote repressed or unconscious material. An amusing illustration of this fallacious assumption concerns the symbolic expressions of Nazi leaders who were given personality tests while awaiting trial in Nuremburg. These findings have been described in an excellent book by Dr. Gilbert, the prison psychologist (3). One of those tested was Colonel Hoess, the S. S. official in charge of the Auschwitz concentration camp. It has been estimated that this man was directly responsible for the deaths of over two million prisoners. As such he probably ranks among the most murderous and sadistic human beings who have ever lived. A book reviewer for a psychological journal noted with surprise that the fantasy test expressions of Colonel Hoess were loaded with savage, cruel hostility. This led the reviewer to wonder why Colonel Hoess would have repressed sadism in his TAT stories when he overtly acted out so much aggression in his behavior.

It seems clear that this psychologist was erroneously equating fantasy productions with repressed or unconscious material. The theory of variability developed by the Kaiser Foundation research (see Chapter 13) would expect that a person who expresses such intense hostility and who rigidly avoids tender, humanitarian feelings at Levels I and II would probably be unable to tolerate positive feelings even at the level of symbolism. Colonel Hoess, we suspect, was least anxious when he was employing cold, sadistic security operations. It is not surprising that the same avoidance of affiliative emotions reappeared at Level III-T. Three-layer expressions of the same theme are typical of chronic maladjusted characters.

Variation in Depth of Symbol Instruments

The third issue evolving from this sample case concerns the definition of levels and sublevels. At Level II we obtain the picture that the subject wishes to present to us—his conscious reports. At Level III he communicates in an indirect language that need not be bound by the limits of the real world. We have assumed that Level III is related to the private world. All human beings have a world of mental reservations which are more or less distinct from what they directly express. The different layers of symbolic behavior, it seems, come closest to expressing these.

But in many cases Level III hero and other scores are the same as Level II. The same themes are emphasized or avoided at both levels. The bland hysterical personality just presented was one such case. The sadistic Nazi executioner whose symbols were hostile is another such case. Still other patients stress pessimistic themes. They are depressed and bitter at Level II and an equally unhappy blackness stains their symbols. We surmise that trustful, tender emotions are so threatening to these patients that they must avoid them even in fantasies.

When the autisms of Level III are the same as the conscious descriptions of Level II, a puzzling question occurs. In this event it would seem that the private language is the same as the overt and conscious. This is faintly paradoxical. A confusion of levels is suggested. Since the private is also public, it suggests either that these patients have no thoughts that are exclusively private (i.e., secret) or that the symbols have failed to express the private. If the first conjecture is true, then the subject is unusually frank and honest—having, as it were, no mental reservation. If the second is true, then the subject is unusually repressive and secretive—he succeeds in blanketing his symbols with the same avoidance tactics that characterize his conscious expressions. The former would be bluntness and insight. The latter would be evasion and symbolic denial.

According to the theory developed in this chapter, if symbols duplicate the extreme imbalances of the conscious level, then considerable information about the patient's anxiety system is available. The subject compulsively avoids hostility in consciousness. Even in symbol he cannot tolerate an expression of the negative. If he does have private feelings of bitterness or aggression, they are not allowed symbolic expression. He does not dare let his symbols express his private feelings. Level III instruments (e.g., TAT tests) are, in this case, tapping only Level II. They do not "dig down deep enough." A very thick layer of defensive avoidance exists—so that the Level III instruments fail to get at the private world.

For some patients in some situations projective tests such as the TAT fail to reach anything different from conscious report. Consider a patient who covers feelings of distrust and deprivation with a facade of extroverted congeniality. If he takes a TAT in connection with applying for a desirable job, the underlying feelings may not appear in his fantasy stories. The same patient applying for therapeutic help in the psychiatric clinic may produce TAT stories which express his feelings of sorrow and defeat. The same person, were he attempting to "buck for a medical discharge" from the Army, might overexaggerate his depressive feelings on the TAT—they might even be picked up by Level II instruments.

The fact that we obtain Level III fantasy protocols does not mean that we are necessarily tapping the private world of the patient. Methods of measuring fantasy vary in depth. The "preconscious" self in some subjects is closer to consciousness than the images of symbolic others. Dreams seem to produce themes which are most distant from conscious report and thus deeper. To use Freudian terminology, some parts of some dreams seem to tap the primary processes characteristic of schizophrenic or infantile thought. Projective tests and fantasies are generally "preconscious" and probably tap secondary processes.

Level III instruments might be compared with drilling machines which tap geological strata. We cannot assume that the TAT or a fantasy automatically taps private feelings. The depth and thickness of the strata of conscious report is a crucial and variable factor. As illustrated in Figure 22, a flexible person with minimum anxiety (Case 2) may confide his "preconscious" feelings in interviews. He has some conscious awareness of his ambivalences and is able to discuss them. When the conflict is more severe and anxiety greater (Case 3) more indirect instruments may be required to hit the private "layers." This type of patient may present the same picture in a check list and even in therapy interviews. The TAT themes and dreams may indicate the other side of the ambivalence. In other cases (Case 4) the anxiety accompanying certain interpersonal emotions is so great that they do not appear in the expressions of the "preconscious" self. The absent themes may be projected on the "preconscious" world or they may appear only in the subliminal expressions of Level IV.

Determining the Depth of the Measuring Instrument

Use of a Level III test thus does not guarantee that the "preconscious" will be discovered. This fact does not in any way lessen the value of these tests. They always assist in determining the rigidity and depth of the defensive processes. A vital part of interpersonal diagnosis is to determine the amount of anxiety and the way it operates to inhibit or deny certain touchy emotions.

The interpretation of a projective test or dream is greatly facilitated if we know the depth of the private world and the "thickness" of the conscious defensive processes. These are determined in two ways.

As soon as the data are obtained from a Level III test we compare them with the data from Level II. If the symbols clearly duplicate the rigidities of Level II, then we estimate the conscious defensive processes extended down to the depth of the test. The more rigid the similarity between the symbolic instrument and Level II—the greater the anxiety, the thicker the defensive strata. In these cases the thematic

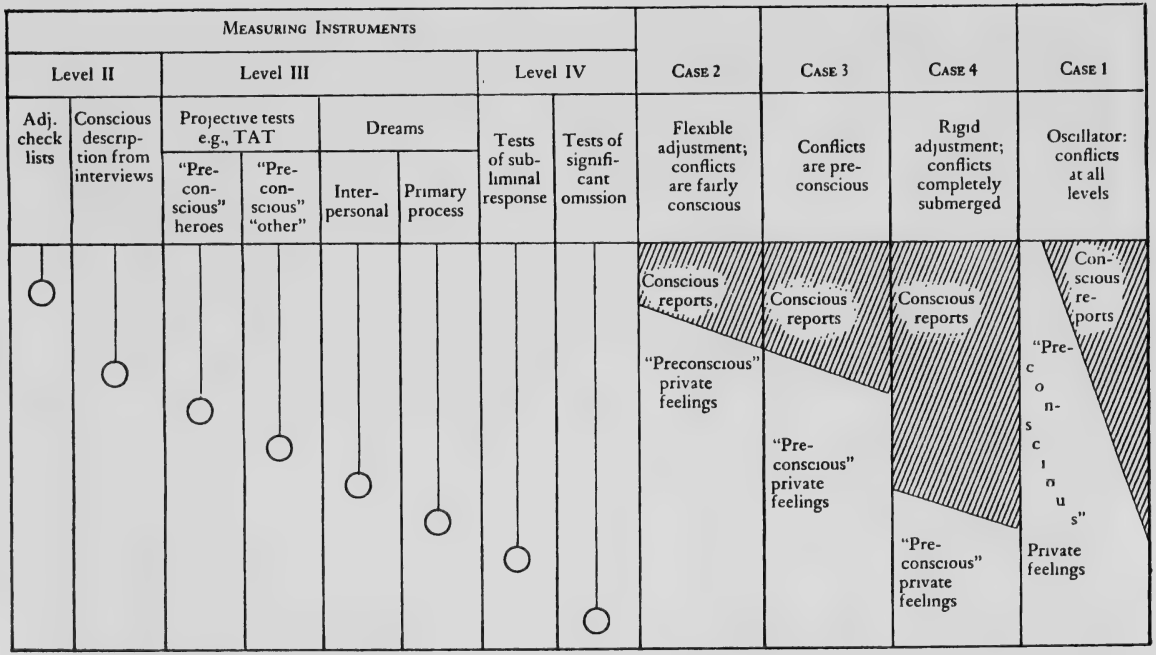


Figure 22. Hypothetic Arrangement of Measurements from Different Levels on a Depth Continuum

aspects of Level III add nothing new. As each additional depth test repeats the same themes, we learn nothing new about *what* themes are present in the elusive warded-off private world—but we do learn something about *how deep* it is and *how much anxiety* is tied to it. The first way of determining the depth of the measuring instrument is to compare its themes with Level II. The more discrepancy, the further from consciousness.

A second method for determining the depth of the measuring rod involves use of internal cues of defensiveness. The two best internal cues for estimating defensiveness from projective tests are misperceptions of stimuli and avoidance of specific themes. These issues are discussed in the next chapter.

Situational Relativity of Symbols

Another factor which exerts strong pressure on symbolic expressions concerns the motivation of the patient in the particular situation. Consider a subject whose private feelings concern weakness and despair. Suppose he is applying for a job which entails executive responsibility, and as part of the application procedures is administered a fantasy test. Since the job situation would tend to motivate the expression of strength and assertion—the expression of his private feelings would be threatening. The feelings of inferiority and depression would, therefore, not be likely to appear. The subject might really have the wishful fantasy of retreating from the demands of the world into an isolated, lonely, passive life. He might secretly yearn to be a forest-fire watcher or a beachcomber. But if the employment interviewer asks him projective questions about his hopes for himself, he might respond with the wishful statement: "I want a responsible, managerial job with a big company." We are, in this last statement, obviously not tapping the symbolic level. Level III is being used to support the overt presentation.

The cultural situation in this example was the "job application." The cultural situation we are concerned with in this book is the psychiatric clinic. We are attempting to develop a functional diagnostic system which will lead to predictions about clinic behavior. When patients come to a psychiatric clinic for diagnostic evaluation they vary considerably in their motivation. Their symbolic productions will vary considerably. Many patients sense psychological evaluation and therapy as a threat to their imbalanced, inflexible adjustments. These patients may avoid in their fantasy tests the same themes that cause them anxiety at Levels II and I. Motivation of the patient, as well as the source and amount of anxiety, is a complicating factor in symbolic interpretation.

This is not a particularly distressing complication to the psychologist evaluating the patient. Certainly we concede that motivation varies from patient to patient and these variances influence the Level III material. But "amount of motivation," far from being a distracting irrelevant factor, is actually most central to prognosis. If motivation effects the production of symbols, then symbols can help estimate the amount and kind of motivation. They can help plan the correct therapeutic program that works with and does not clash headlong against the unique defensive set-up of the particular patient.

Let us recall the hysterical patient (page 181) who presented sweet symbols behind a facade of sweetness. The TAT themes duplicated the conventional, pious traits of Level II. This suggests that the defensive structure is "thick"—the anxiety accompanying antisocial or negative feelings is very high. The patient might be panicked by being referred to psychotherapy. He might react with a severe anxiety attack. Most likely, he would react by increasing the bland denial of pathology. Both of these reactions would postpone the onset of effective psychological help.

At the Kaiser Foundation Psychiatric Clinic a patient with such a hysterical "normality syndrome" would not be rushed into psychotherapy. The nature of treatment might be explained to him. The intake worker might discuss with the patient (in nontechnical language) the nature of his current adjustment—by referring to the patient's own claims to health and hypernormality. This is done supportively. To use psychoanalytic terminology, it is done "from the side of the ego." The rigid claiming of goodness is not attacked as a defense but might be praised as a valuable means of adjustment. No speculation is made about underlying motivation. The advantage of living with the present adjustment (and the symptoms it involves) might be discussed. The function of psychotherapy as possibly leading to different solutions might be mentioned, but not pushed. The patient is offered the opportunity to return to the clinic at any later date if symptoms worsen or if he feels it worthwhile to learn more about his patterns of living and the possibility of changing them.

This process might be called "planting the seed." The TAT, in this case, provides the information that, at present, this patient is deeply committed to hysterical bland techniques of adjustment. Even in fantasy these motives appear. The TAT predicts that exploration of other feelings is, at present, not likely. It predicts that the patient in the immediate future is moving away from and not toward his warded-off feelings.

Level III thus has many sublevels. Some of these are determined by the nature of the measuring instrument. Dreams appear to be the

TABLE 5

PERCENTAGE OF DIAGNOSTIC TYPES (LEVEL III-T) FOUND IN SEVERAL CULTURAL SAMPLES

		Percentage of Cases Diagnosed as								
Institutional or Symptomatic Sample	*N*	Managerial-Autocratic *AP*	Competitive-Narcissistic *BC*	Aggressive-Sadistic *DE*	Rebellious-Distrustful *FG*	Self-Effacing-Masochistic *HI*	Docile-Dependent *JK*	Cooperative-Overconventional *LM*	Responsible-Hypernormal *NO*	*Total*
Psychiatric Clinic Admissions	103	15	10	12	13	12	13	6	19	100
Hospitalized Psychotic Patients (Male)	38	16	8	24	16	10	10	5	10	99
Group Psychotherapy Patients	41	15	17	15	12	5	7	15	15	101
Individual Psychotherapy Patients	30	23	23	7	10	10	7	10	10	100
Overtly Neurotic Dermatitis Patients	30	3	23	17	10	13	7	3	23	99
Self-Inflicted Dermatitis Patients	57	21	24	24	16	9	0	2	4	100
Unanxious Dermatitis Patients	72	22	32	15	6	7	4	4	10	100
Medical Control Patients	41	29	41	10	5	0	0	0	15	100
Ulcer Patients	19	16	11	21	16	0	26	5	5	100
Hypertensive Patients	27	11	22	15	26	4	11	7	4	100
Middle Class Obese Patients (Female)	97	27	24	19	10	3	2	5	10	100
Total	555									

deepest sublevel. Wishful fantasies and projective tests are less deep. These sublevels vary from situation to situation. In six months the patient described here may return to the clinic. He may see it this time, not as a threatening institution ready to expose his antisocial feelings. He may be less defensive. His thick protective strata (which are measured by the extent to which Level II themes penetrate and duplicate Level III data) may be considerably diminished. His second testing battery may show the same conscious description but a more changeable TAT. He would then be considered more ready to deal with his conflict between bland sweetness and the underlying feelings.

Incidence of Level III-T Behavior in Various Cultural Samples

Detailed summaries of the research findings involving Level III behavior are presented in the clinical chapters and Appendix 3. At this point the percentage of Level III-T types found in several symptomatic and institutional samples are presented in Table 5.

It will be observed that psychotics manifest "preconscious" sadism (*DE*) and distrust (*FG*); medical controls (normals), underlying power (*AP*) and narcissism (*BC*); obese patients, power (*AP*) narcissism, and hostility; ulcer patients, an intense amount of underlying dependence (*JK*), etc.

Significance tests and discussion of the clinical and theoretical implications are presented in Chapter 24.

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10

The Level of the Unexpressed: Significant Omissions[1]

The levels of personality described in the last three chapters have moved steadily from overt observable behavior (Level I) through conscious description (Level II) into the two private or underlying layers of the "preconscious" (Level III Hero and Other). This sequential progression from the external to the internal brings us now to the deepest level of personality—Level IV.

This is called the level of the unexpressed. It comprises those interpersonal themes which the patient consistently, significantly, and specifically omits in the three other levels.

The Two Criteria for Defining Level IV Themes

The essence of Level IV themes is that they not be expressed in action, in consciousness, nor in the "preconscious." The first criterion is that the themes be avoided at these levels. This negative evidence cannot in itself be taken as proof that the themes are "dynamically" absent nor that they exist in deeper strata of the personality. To accept this absence at one level as a sign of presence at another level is to commit the ancient fallacy of reversal which was discussed in the preceding chapter.

The second criterion for defining Level IV requires evidence that the themes are actively avoided. It must be demonstrated that the subject selectively and stubbornly refuses to respond to these themes when they are appropriate in the situation. It is not enough to report that a patient fails to express a particular cluster of themes—let us say competitive hostility—at the three top levels of behavior. In addition,

[1] This level of personality has not been studied systematically by the Kaiser Foundation psychology research group. The definition and discussion in this chapter is tentative and suggestive. Readers who are interested in the *current* clinical or research applications of the interpersonal system can safely omit this chapter.

it must be shown that he has been exposed to situations in which he is naturally or consensually expected to perceive, react to, or express these themes and that he has refused to do so.

This level of personality has received little empirical attention and is therefore not included in the systematic or clinical studies described in this book. This chapter will present a definition and a survey of some tentative, unvalidated techniques for measuring Level IV. Although in the subsequent chapters no reference will be made to Level IV, the present discussion is included as a preliminary description of this incomplete aspect of the interpersonal system.

From the functional point of view the existence of unexpressed interpersonal themes seems to be of some importance. It might be argued that in clinical practice we are interested, not in the absent motives, but in the strata of ego functions which lie above them and which seem to be organized in warding them off. When we deal with a patient who presents conventional, bland themes at Levels I, II, and III, our diagnostic attention is obviously going to be focused on these ego processes. On the other hand, it is useful to know that interpersonal themes comprise the Level IV significant omissions. These themes can be expected to be anxiety-laden. If the patient is confronted with them, panic may develop. Level IV defines the "touchy spots" most vigorously and desperately avoided.

In the Kaiser Foundation research we have tended to concentrate on the three more overt levels. In psychoanalytic language we have been attempting to develop an *ego psychology*. Research is now being planned which will investigate some of these aspects of the significantly omitted.

The methods being considered for these future studies will now be reviewed.

The Measurement of Unexpressed Themes

It has been pointed out that there are two empirical criteria for the measurement of Level IV themes. They must negatively be demonstrated to be significantly absent at the three top levels; they must positively be demonstrated to be actively avoided. Two separate measures of Level IV are therefore available—the omission and the avoidance scores. These two criteria will be treated separately.

The Measurement of Omission of Interpersonal Themes. The first criterion is easily measured. The scores at Levels I, II, III Hero, and III Other are examined to see what behaviors are consistently avoided. This can be done by inspection of the profiles or by means of arithmetical indices.

Figure 23 presents the profiles of an illustrative patient who has clearly failed to express rebellion or unconventional themes.

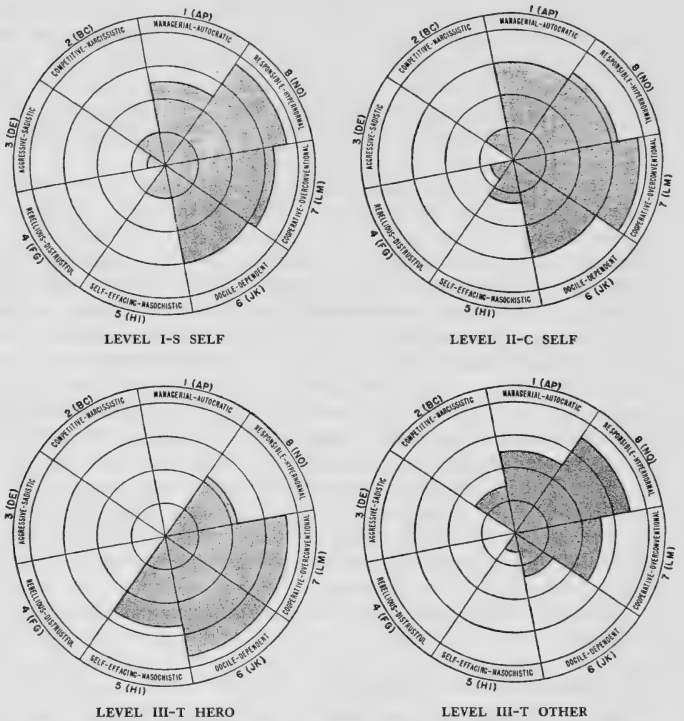


FIGURE 23. Profiles of Interpersonal Behavior at Four Top Layers of Personality Illustrating the Avoidance of Rebellious (*FG*) Behavior.

By inspection we see that the *FG* and *DE* octants are conspicuously neglected. The Level I profile is obtained from sociometric ratings of other group therapy patients. It will be observed that the fellow group members did not use any *FG* or *DE* words to describe this patient's impact upon them. In his Level II-C self description he completely denied any of these behaviors. Even his fantasy heroes and others fail to receive any of these motivations. It is possible to determine by glancing at these four interpersonal profiles that there is a con-

sistent tendency to avoid the expression of resentful, rebellious, hostile themes.

In addition to the diagnosis of Level IV omission by inspection of the profiles it is also possible to employ mathematical techniques. These allow the Level IV omission profile to be plotted in terms of a single summary point. These are determined by the horizontal and vertical indices just as in the case of the three overt levels.

There are many ways in which Level IV omission scores can be calculated. It is possible to study at each of the four more overt levels the sectors which the subject neglects. We could study all of the items on the interpersonal check list *not* used by the fellow group members in rating the patient. These could be treated like the "yes" scores, converted into the horizontal and vertical factors and plotted. This provides an omission-at-Level-I score. The same could be done for the interpersonal check list self-description at Level II.

We want, however, a single summary score which will give the over-all pattern of what is omitted at Levels I, II, and III. A single way of estimating the Level IV omission score is to take the standard score indices for Levels I, II, III Hero, and III Other (which are used to plot the diagnostic people) and to establish the mean horizontal and vertical indices for these four scores.

For the patient profiled in Figure 23 the scores were:

	Vertical Standard Score	*Horizontal Standard Score*
Level I-S	64	66
Level II-C	62	70
Level III-T Hero	41	94
Level III-T Other	60	85
Total	227	315
Mean	$\frac{227}{4} = 57$	$\frac{315}{4} = 79$

These two mean indices provide a summary of the themes the patient has *expressed* at these four layers of personality. If these indices are each subtracted from 100 they give a summary of what the patient has avoided at Levels I, II, and III. The mean omission scores for this patient are vertical $= 43$, horizontal $= 21$ (see Figure 24). This is located in the *FG* octant and indicates that this patient compulsively and markedly omits rebellious, unconventional, and bitter behavior in his expressions at Levels I, II, III Hero, and III Other.

The Measurement of Significant Avoidance of Interpersonal Themes. There are two criteria for determining significant omis-

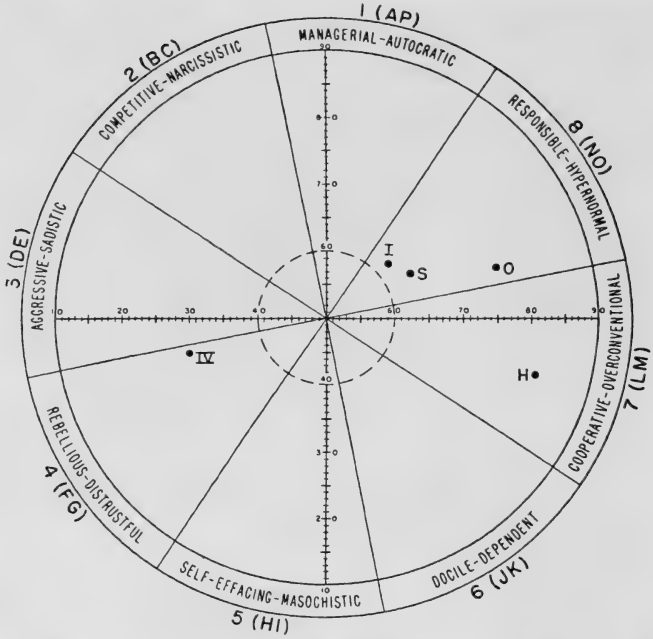


FIGURE 24. Diagnostic Grid Containing Summary Points for the Four Top Layers of Personality and the Level IV Omission Score Calculated by Subtraction. *Key*: Radius of diagnostic grid = 6 sigmas, *I* = Level I-S; *S* = Level II-C description of self; *H* = Level III-T (Hero); *O* = Level III-T (Other); IV = Level IV omission score.

sions at Level IV. The first is to demonstrate that certain themes are consistently omitted at the upper levels. A method has just been presented for determining this type of Level IV score.

The second criterion involves the demonstration that these themes are actively avoided by the patient at the upper levels. The *omission* score just calculated for Level IV indicates that the patient has "claimed" or "expressed," and by a process of subtraction we obtain the Level IV index. The *avoidance* score is obtained in a different manner.

There are at least three techniques for estimating the tendency to avoid themes at Levels I, II, and III. The first of these is based on statistical procedures and estimates the tendency to fail to perceive or

express interpersonal themes where, consensually, most others do perceive or express them.

It is possible to determine for each interpersonal test item at each level the probability of its being expressed. The interpersonal check list employed at Levels I and II has been subjected to intensive statistical analysis. The percentage of the clinic sample expected to respond to any particular word has been determined. The 128 words on the check list have been classified into four groups along an intensity dimension in terms of its probability of occurrence. *Intensity 1* includes words which are checked as "true-about-self" by approximately 90 per cent of psychiatric clinic patients. There are minimal amounts of the trait which almost everyone is willing to attribute to himself. *Intensity 2* includes words employed by 50 to 90 per cent of the clinic population. *Intensity 3* employs more intense themes used by relatively fewer (10–50 per cent) patients. *Intensity 4* employs extreme loadings of the theme which are rarely checked by clinic patients. Here are illustrations of check list items at the four intensities for the interpersonal variable *D*, which includes themes ranging from appropriate sternness to punitive sadism.

Intensity 1 (very common, expected):	Able to be strict
Intensity 2 (average-moderate):	Stern but fair
Intensity 3 (fairly intense):	Sarcastic
Intensity 4 (rare-extreme):	Cruel and unkind

Each item on the check list is thus weighted in terms of its consensual or average usage. If a patient does not check the Intensity 1 word for any interpersonal variable, he is failing to attribute to himself a mild amount of this theme which 90 per cent of the clinic population does express. In determining the Level II diagnostic indices, the weightings of the items are not considered. All the words used in every octant are fed into the formulas.

To determine the significant avoidance score these weights are of usefulness. At Levels I and II which employ the check list we can study the pattern of avoidance of Intensity 1 and 2 items. Weights can be assigned so that the failure to check these mild, average, statistically common items about the self can be cast into numerical indices of significant avoidance.

At Level III (as measured by the TAT) the test stimuli are pictures which portray human beings in interaction. The probability of any given interpersonal theme being expressed in reaction to any particular card has been determined. Thus we discover that 85 per cent of the clinic population respond with the fantasy theme *H1* (sorrow or

guilt) on card 3BM, whereas less than 2 per cent will produce a story involving *AP* (dominant power). This information makes it possible to weigh the *thematic pull* of every card on the TAT (or any other fantasy test). Patients who consistently resist the card pull for any particular interpersonal theme can be assigned Level IV avoidance indices which are based on the percentage expectance.

This general method for measuring significant omission has been previously described by William E. Henry in his monograph on TAT Analysis (1). He defines two areas of TAT content interpretation: *positive content* and *negative content*. "The difference between positive and negative content can be summarized in this way: the analysis of positive content is concerned with what the subject actually has said, the analysis of negative content is concerned with what the subject has failed to say and with what he might have been expected to say considering the usual responses made to that picture." (1, p. 37).

Normative and validating research on the significant avoidance scores based on these statistical characteristics of the tests for Levels I, II, and III is now being done. Since these studies have not been completed, the Level IV avoidance scores are not included in this volume.

There are two additional sources of Level IV significant avoidance data which will now be briefly reviewed. Both of these are based on special psychological techniques for measuring the selective factors in memory and perception.

A test of repression developed by Boris Iflund (2) seems to provide an excellent measurement of Level IV data. The Iflund test deals with selective memory factors. It consists of 34 cards, each of which contains a picture. Twenty-eight of these are illustrations of personality needs (as listed by Murray). Six pictures are *buffer* cards which contain nonloaded (street or landscape) scenes. The subject is told that he will be shown the stack of cards, each card being exposed for 5 seconds. He is told that after the entire deck has been shown to him he will be asked to recall as many as he can. After the subject has recalled as many as he can the nonbuffer (i.e., thematic) cards which he recalled are removed from the deck. The same process of presentation and recall is repeated until all cards have been recalled. In individual administration an inquiry period after the test is employed to clarify accuracy or misperceptions of the cards.

This test is based on the psychoanalytic theory of repression. It is held that the themes which the subject remembers last are subject to more repression than those he recalls first. The serial order of recall is believed to relate to intrapsychic defensive processes holding sensitive themes for awareness.

To the extent that the Iflund test does isolate warded-off themes, it can be used as an estimate of the stratification of personality and as an indicator of Level IV themes. The most-forgotten themes, i.e., those remembered last, should be close to the Level IV omission score.

Research on the Iflund test is currently uncompleted and is not included in the systematic and diagnostic studies reported in this book.

A third technique for determining Level IV significant avoidance scores has been suggested. This involves the theory of perceptual vigilance or perceptual defense in relation to sensitive or warded-off emotional stimuli. Methods have been developed by experimental psychologists for determining the level of perceptual readiness to respond to varied stimuli. The tachistoscope (which is a machine for exposing stimuli cards to an observer at split-second speeds) is employed in these experiments. There is some evidence suggesting that the speed of recognition varies in relation to the emotional loading of the stimuli. Subjects whose personalities are mobilized to ward off hostility from awareness tend to require slower speeds of presentation in order to perceive hostile motifs on cards.

To the extent that this theory of motivated perception and perceptual defense holds true, tachistoscope recognition speed becomes an estimation of Level IV. The themes which are recognized most quickly should be those which are expressed or consciously claimed at the upper levels. Those which are recognized at the slowest tachistoscope speeds should also be avoided at the levels of action and conscious report. Perceptual defense thus becomes an estimate of the significantly avoided and a measure of Level IV.

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11

The Level of Values: The Ego Ideal

There is another area of human behavior which because of its functional value and theoretical uniqueness has been designated as one of the operating levels of personality. This is Level V—the level of values. It includes the interpersonal aspects: ideals held by the individual—his conceptions of "rightness," "goodness," of what he should like to be.

The last four chapters have presented Levels I through IV, working sequentially from the public overt aspects of behavior into the more private, unexpressed areas. At this point the trend is reversed. The numerical designation of Level V suggests that this is the deepest level—which, of course, it is not. Level V is concerned with consciously reported ideals. The subject is asked to list, or describe, or check his picture of how he should like to be.

Level V Is an Independent Area of Personality

Level V, as presently measured in the interpersonal system, is not a very complicated or deep measurement. It simply gives us a picture of how the subject wants us to see his ideals. It tells us which values he consciously stresses. The subject may privately have different goals and stress different feelings. His private value system may be in contradiction to his openly reported principles.

The working procedures of the Kaiser Foundation research project simplify this complexity of values. The general empirical approach of this system of personality is to select several narrow operationally defined areas of behavior (which are called levels) and to utilize the same matrix of interpersonal variables to measure behavior at these levels. The levels are defined by the nature of the data, that is, by the way it is obtained, by the technical context of the measurement process. If the subject produces fantasy themes in response to projective test stimuli then Level III is defined. When he attributes interpersonal themes to his ideal then Level V is defined.

Although Level V is a rather simple measure of consciously reported values, it possesses a clear-cut statistical independence. That is to say, it does not duplicate the other levels. Patients' descriptions of their ideals are very often quite different from their conscious self-descriptions and their fantasy expressions. This measure seems to vary independently of the other levels. This offers reasons for expecting that it may serve a unique psychological function and possess a unique clinical application.

The Universality of Value Systems

The Level V value system gives us a picture of the interpersonal standards which the subject holds for himself. The notion of ideal, it should be noted, is widely accepted and natural. During our testing procedures patients readily take to the task of describing their ideal. The concepts of "right" and "good" and the interpersonal themes associated with these values seem to be taken for granted.

The vital and universal process of idealization has been recognized by almost every personality theorist. Kluckhohn and Murray (1, p. 21) for example, state that: "One of the important establishments of a personality is the *ideal self*, an integrate of images which portrays the person 'at his future best,' realizing all his ambitions." The related concepts of ideal, superego, and introjection have been receiving increasing emphasis in psychoanalytic theory.

Ethical standards appear to exist in all cultures. In an earlier chapter the universality of symbolic behavior was noted. The same can be said for moral standards of conduct. It is hard to conceive of a society or a social group which does not possess many principles of "rightness" and "wrongness." Not all the members of a society necessarily share (publicly or privately) the same set of values. Some may assign positive values to force, others to deceit, others to charity. In many societies women may publicly accept standards which are different from men's.

Although the specific qualities to which "goodness" and "badness" are attached may vary, what seems to remain constant is the assumption that there are standards of right and wrong.

It is these principles which we tap in Level V when we study the interpersonal themes which the subject *idealizes* and those which he avoids attributing to his ideal.

The Function of Value Systems

This poses the questions: Why do individuals develop standards and ethical principles of behavior? What is the function of these ideals?

A detailed discussion of this topic is well beyond the scope of this book, encompassing as it does the genesis and meaning of ethics and morals. The general assumption about human motivation employed in this book does suggest certain approaches to these questions.

The basic function of the individual's interpersonal behavior is to ward off survival anxiety. Any personality pattern can be viewed as an attempt to come to terms with the social environment. In this light the development and maintenance of value systems can be seen as providing several bulwarks against anxiety.

First of all, the acceptance of certain ideals tends to link the individual to strong forces in his world. By taking over and expressing these ideals the subject identifies himself with powerful images of rightness. The standards may come from his parents, from his conception of religious figures, from the standards held by his social groups, etc. Generally they come from all these sources. Symonds (2) has described the process by which the individual combats his feelings of weakness and develops a feeling of omnipotence by taking as models and values those of the group: "One looks for support by acceding to the wishes of society through its laws and customs, so that one feels secure as a member of the group and derives power from the group. A still further development is to align oneself with the universe and to look to God for strength. So the religious person, by obeying the rules of morality, is continuing this process of gaining strength for himself by aligning himself with superior forces."

By taking on standards and ideals the individual wins approval and attempts to ward off disapproval. Heightened self-esteem and the avoidance of shame and inferiority can be achieved by the acceptance and expression of value systems. It appears that all human beings maintain this one unique area of their personality which reflects their conception of what they should or could be.

Like behavior at other levels, the value system may play a destructive and unsettling role in the total personality structure. Ideals which are too elevated or standards which are too strict may lead to severe conflict with other levels. Thus the Level II self-conception may fall far short of a rigid, demanding set of ideals—with a resulting feeling of guilt and self-dissatisfaction. This phenomenon has been noted at other levels where extreme, exaggerated behavior at one level creates new circles of conflict and anxiety.

Human beings presumably develop standards in an attempt to lessen anxiety, win approval, or to win security through linkage with powerful parental and societal forces. But the complexity of social adjustment generally creates the tragic paradox of human nature—the tech-

niques for avoiding anxiety at one level are related to the activities of other levels. They cause tension at other levels which in turn may increase anxiety and lead to an increase in the original behavior.

Kluckhohn and Murray (1) have commented on certain aspects of this process. They point out the relationships of aspirations and ideals to the "frustration and dissatisfaction" of overt behavior. "High aspirations can cause unhappiness and discontent, while the process of lowering aspirations to realizable levels is functional."

This process of relaxing standards is, however, not a simple or voluntary procedure. The ideals held by individuals, like the behavior expressed at any other level, are not easily changed. This is, we presume, because they play a vital functional role in the total personality pattern. Human beings develop ideals for the very important purpose of warding off survival anxiety and avoiding shame, weakness, and disapproval. These ideals develop and are expressed in reciprocal response to the activities of other levels. Frustrations (and the accompanying anxiety produced) at Level I may result in a lowering of the associated Level V ideals; or they may result in an increase. Interpersonal behavior at any level of personality has the function of warding off anxiety. This behavior can shift in response to stimuli from the external environment or in relationship to pressures or changes from other levels of personality. A most complex chain of multilevel processes is involved in any interpersonal pattern at any single level. The interpersonal ideals which we measure at Level V are not exceptions to this principle. In the latter sections of this chapter some of these multilevel relationships (the indices of self-acceptance and idealization) which involve Level V and the other establishments of the personality will be reviewed.

The Measurement of Interpersonal Ideals

To obtain measurements of Level V behavior it is necessary to have the subject communicate his system of values. His ideals are then categorized in terms of the continuum of sixteen interpersonal variables. These scores are then treated in the same way as the scores from other levels; they can be formalized, standardized, diagramed, and then related to the total multilevel pattern.

There are many methods for obtaining the raw protocol data for Level V. The subject can be asked to describe his ideals either in interview or in essay form. He can be given check lists or questionnaires about his values. Regardless of how the data are collected the rating procedure is the same. The interpersonal aspects of these expressions are coded into the language of the interpersonal system.

At the present time the Kaiser Foundation project is employing three methods for obtaining Level V data.

Scores from the interpersonal adjective check list on which the patient rates his ego ideal are coded Level V-C.

Ratings by trained personnel of the subject's ideals as expressed in diagnostic interviews are coded Level V-Di; in therapy interviews, Level V-Ti.

The Kaiser Foundation research project routinely obtains Level V protocols (along with measures at seven other areas or levels) as part of the personality test battery. The key measuring instrument in this process is the interpersonal check list. Each patient uses this check list to rate first himself then his parents, his spouse, and his ego ideal. The instructions for the Level V-C test request the patient to check the items which describe "his ideal, his picture of himself as he should like to be." The patient is thus allowed to describe his value system on the same measuring instrument which he has employed to describe himself and three important family members. The empirical advantages of this procedure for comparing behavior at different levels has been previously discussed.

Figure 25 presents the Level V-C profile of a patient tested in the Kaiser Foundation clinic. For comparison we have also included the

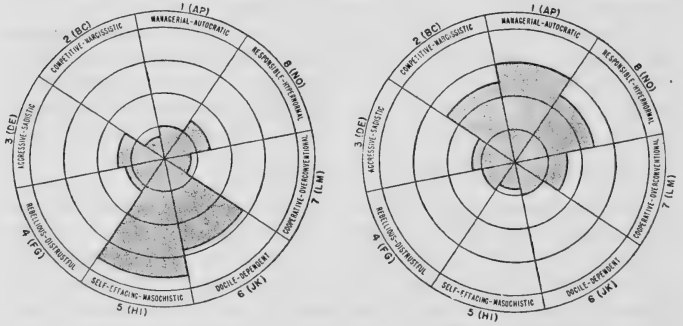


FIGURE 25. Illustrations of Level II-C and Level V-C Profiles for a Docile Patient Whose Ego Ideal Involves Strength.

Level II-C self profile. These diagrams indicate that the patient sees himself as a weak, docile person. His ego ideal stresses themes of strength and power.

The Functional Value of Level V

Level V is a simple but useful diagnostic tool. Its first and most obvious application is the insight it gives us into the subject's value system. Human beings vary in the interpersonal themes they idealize. Some stress congeniality and conventional agreeability. Others emphasize strength and assertion. Some prize competition. Others are concerned with frank, blunt honesty, or modest reserve. There seem to be relationships between diagnostic types and the nature of the ego ideal. Patients who stress dominance or submission at Level I-M emphasize pure power in their ego ideal. Patients who manifest either hostility or love at Level I-M are significantly less concerned with power and more involved with friendliness in their ideals. In other words, subjects whose actions fall along the vertical axis place their ideals at the top of the vertical axis (dominance). Subjects whose actions locate on the horizontal axis place their ideals close to the horizontal axis (affection).

Another and perhaps the most important use of the Level V score is obtained by comparing it with other levels. The discrepancy between ideal and Level II Self provides an index of *self-acceptance.* This variable plays a most crucial role in arousing motivation for therapy. Similarly, the kind and amount of discrepancy between the ideal and the conscious descriptions of family members provides another set of valuable indices. These discrepancies are called the indices of *idealization.*

The essence of these and the other interlevel discrepancies between the ego ideal and the other areas of personality is as follows: once we systematically locate the subject's ego ideal we can compare all the measures from the other levels of personality to see how close they fall to the ego ideal. Different theoretical and clinical implications are attached to these idealization indices.

Limitations of the Level V Score

The measurement of ego ideal employing the interpersonal adjective check list is somewhat limited because of the tendency of all patients to stereotype their ideals. In one sample of 207 routine clinic intake patients, 53 per cent placed their ego ideal in the managerial octant and 37 per cent in the responsible-hypernormal octant. This means that 90 per cent of all patients had ego ideals in the upper right-hand quadrant and less than 2 per cent placed their ego ideal in the lower (weak) half of the diagnostic circle.

This homogeneity is a cultural stereotype. We might expect that some other cultures would stress aggression and some (oriental, for

example) might idealize the passivity and modesty which American urban subjects so dramatically devaluate.

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12

A System of Interpersonal Diagnosis[1]

We have suggested in Chapter 6 that functional diagnosis of personality involves two basic dimensions—interpersonal behavior and variability. The preceding five chapters of this section have dealt with the concepts and measurement techniques by which we systematize the interpersonal dimension of personality. We have defined the interpersonal variables by which security operations of the human being can be classified. We have considered the levels at which this behavior is observed.

With these theories and methods as background, it is now possible to consider the application of this personality system for interpersonal diagnosis.

Purpose of Personality Diagnosis

An examination of psychiatric nosology reveals considerable variation in terms. Some diagnostic categories refer to the symptomatic picture. Some are clearly moralistic or evaluative epithets, e.g., *inadequate personality*. Some refer to character traits, e.g., *obsessive-compulsive*. Some are global terms for disease entities which summarize many specific factors, e.g., *schizophrenic* and *hysteric*.

In order to evaluate these terms it is necessary to inquire into the purpose of personality diagnosis. Just why do we need a nosology? Just what is it to be used for?

Psychiatric or personality diagnosis terms actually have many differing uses, depending on the institutional or cultural context. In the

[1] Appendix 4 presents an interpersonal diagnostic report written for the psychiatric clinic. This report serves as a clinical illustration of the theory and methodology presented in this chapter. The execution of multilevel interpersonal diagnosis is facilitated considerably by the use of a printed booklet in which the tabular and diagrammatic steps involved in diagnosis are organized. This "Record Booklet for Interpersonal Diagnosis of Personality" also includes a simplified procedure for calculating interlevel discrepancies (variability indices), for plotting them on a profile sheet, and for preparing verbal summaries of the indices. A copy of this booklet is presented in Appendix 4.

legal situation, to take an extreme example, the diagnostician is usually called upon to determine whether the patient is grossly psychotic or not. The judicial authorities are generally not the least bit interested in the fine shadings of ego organization or the complexities of the oedipal situation. A single "yes" or "no" as to the sanity of the subject is generally sufficient.

Many psychiatric centers employ broad categories which are just as gross and dichotomous. Some admitting wards, observation centers, etc., have the sole mission of deciding where the patient will be routed. If the patient is markedly psychotic, he goes to a psychiatric hospital; if he is neurotic, he is sent back to the community. For such purposes, these agencies do not require subtle differential, diagnostic categories.

In most psychiatric hospitals the diagnostic decisions are somewhat more complex. Differential diagnosis relates to differential treatment plans. One type of patient may be assigned to electric shock therapy, another to insulin treatment. Therapies of this sort are aimed at symptom removal and not character reorganization. The diagnostic and prognostic terms, therefore, tend to focus on the descriptive or symptomatic aspects of behavior. An interpersonal or characterological diagnostic system is, in this case, not the most relevant tool. In deciding between two types of physical therapies the nature of the patient's interpersonal reflexes, the type of repressed motivation or the expected transference are not the central criteria.

Descriptive diagnosis as presented in psychiatric textbooks is generally considered to be crude, unreliable, and nontheoretical (1, 2, 3, 5). The main reason for the slow progress in psychiatric nosology parallels, perhaps, the general crudeness of most psychotherapeutic techniques. Medical diagnosis is, by comparison, extremely specific and definitive because of the differentiated maturity of medical knowledge. There are hundreds of detailed medical diagnoses all pointing to specific medical treatment plans. By contrast, psychological theory and psychiatric practice is most limited. This situation seems, however, to be improving.

R. E. Harris, for example, points out: "With progress in psychotherapy, diagnosis is becoming more and more a matter of assaying 'therapeutically relevant' variables, i.e., those which are related to what happens in therapeutic interviews—the resistances, the defenses, the strength of the ego, the amount and quality of the anxiety and its sources, the quality of reality testing, etc. These variables are defined and understood both as they are inferred from the historical reconstruction of the life history and, more importantly, as they appear in the interaction between therapist and patient." (4, pp. 27–28)

The modern American psychiatric clinic is taking on an increasing number of prognostic decisions. A survey of the intake procedures of the Kaiser Foundation Psychiatric Clinic revealed that there are over twenty ways of disposing of a case. Most of these decisions are based on characterological or interpersonal factors: the amount of ego-alien anxiety, the interpersonal techniques for handling anxiety, the kind and amount of motivation for personality exploration and change. Certain "pure" hysterics and psychosomatic patients whose bland, ego-syntonic, hypernormal adjustments mobilize against psychotherapy might be sent back to the referring physician with recommendations for supportive medical handling. Other hysteric or psychosomatic patients whose personality patterns reveal underlying feelings of depression, anxiety, or deprivation might be referred to specific, carefully delimited therapeutic relationships. Patients are assigned to several kinds of individual psychotherapy depending on the nature of the personality picture. Three types of group therapy are available for certain kinds of patients.

In a psychiatric clinic of this sort interpersonal predictions which define the amount of anxiety and the interpersonal patterns to which it is attached are most useful. For patients beginning the long road of orthodox psychoanalysis, interpersonal diagnosis is less relevant. Transference factors are provoked and dealt with during the lengthy process, and preanalytic predictions might not necessarily save any time or energy. In the clinic, however, where flexibility of treatment program is emphasized, predictions as to expected behavior, expected resistances, and cues concerning the nature of repressed motives are at a premium. Interpersonal variables which measure the social reactivity of the patient, overt and covert, current and future, appear to have the highest functional "cash value."

From the standpoint of practical application and research objectivity, interpersonal diagnostic patterns seem superior to Kraepelinian or psychiatric diagnostic terms. This is not to say that standard psychiatric nomenclature should be or could be abandoned. There are, indeed, several factors which argue against the offhand rejection of psychiatric language. In a following section we shall seek to discover relationships and communalities between interpersonal and psychiatric diagnoses. Such relationships, if they exist, would greatly broaden the functional and theoretical power of both diagnostic systems.

Any personality diagnosis, thus, serves several ends. It provides a classification most useful for administrative, legal, predictive, and research purposes. A more detailed interpersonal diagnosis serves the added function of predicting the kind and sequence of security operations to be expected from the patient.

In the following pages we shall present a diagnostic system comprising 65,536 categories. These are based on the permutations of interpersonal measurements "adjustive and maladjustive" at three levels (four layers) of behavior. This is an automatic diagnostic procedure. It is based on the logic, theory, and methodology which have been discussed in the preceding chapters. There is no clinical judgment or psychological intuition involved in making an interpersonal diagnosis. The personality data are collected and fed into the notational apparatus, and the diagnosis automatically rolls out. In the Kaiser Foundation Clinic the tests of Level I and II are scored by clerical workers; the themes of Level III are rated by nonprofessional technicians. The resulting indices are plotted on standardized graphs, and a diagnosis involving three levels of interpersonal behavior, as well as a diagnosis of variability, is obtained. Not one minute of professional time is required for these systematic diagnoses. (An independent clinical diagnosis is, of course, prepared by the psychiatric intake worker, and the two assessments of the patient are fitted together in the clinical evaluation conference.)

Systematic diagnosis based on multilevel test batteries is much more precise and detailed than clinical diagnosis. It is quite difficult to obtain reliable diagnoses when clinicians use only their own perceptions and observations. Studies of the reliability of psychiatric judgments are notoriously low even when the simplest, broadest fourfold categories are employed (1, 2, 3, 5). If clinicians were asked to select a diagnosis from a list of 65,536 categories, an endlessly long period of intensified training would be necessary to effect any kind of reliability.

The systematic diagnoses we are about to consider require, however, no intuitive decision. The categorization system works something like a table of logarithms or square roots. Much time and some creativity have gone into the development of these mathematical tables —but to use them is a routine, clerical, and reliable procedure. Whatever clinical experience and theoretical competence was available has been built into the classification schema. The application of the system is a rote process. The professional worker then takes the results of the systematic operations and fits them to his clinical knowledge of the case.

Three Systematic Methods for Summarizing Personality

The meaning and function of diagnosis will be made clearer if we compare it with the other methods of summarizing personality data. The Kaiser project has employed three different kinds of assessments of human personality—each with its own purpose and significance and each possessing certain limitations and advantages. These are: (1)

the diagnostic code-formula of personality, (2) the diagnostic profile of personality, and (3) the diagnostic description of personality.

The diagnostic code is a succinct, systematic multilevel label or coded formula which is taken from a finite standardized list of mutually exclusive terms. These terms should be operationally defined. The diagnostic classification should, therefore, be highly reliable. Its primary purpose is to summarize the essence of the multilevel pattern of personality, to make predictions with known probability about certain crucially important aspects of behavior, and to prognosticate the success of specific clinical, therapeutic techniques.

The multilevel diagnostic code can be calculated by well-trained clerical workers. The predictions can also be produced by clerical procedures since they involve the looking up of probability indices based on group statistics. A highly skilled clerical worker with no knowledge of psychological theory could hypothetically assemble the raw data, feed them into the tables and indices, and arrive at the automatic multilevel code diagnosis. This worker could then enter a set of correlation matrices and make probability statements about the patient. Statements of the following nature could be made: "This patient is an overtly autocratic personality; less than 20 per cent of patients with this Level I diagnosis enter individual psychotherapy; of those patients who do enter individual psychotherapy, more than 65 per cent quit within six weeks; of those who enter group therapy, more than 40 per cent quit within six weeks; etc."

The advantages of the diagnostic code include brevity, reliability, finite listing of possibilities, and the fact that it does not require the expenditure of professional energy. The disadvantages are numerous: it has no explanatory value; it predicts only for a group (i.e., in probability figures) and takes no account of the unique complexity of each individual.

The diagnostic profile of personality presents a diagrammatic and numerical summary of the patient's behavior at each level, and of his variability indices. It summarizes his behavior in terms of the interpersonal measurements, and in terms of the operationally defined indices of personality organization. The procedures on which the profile is based have a known reliability.

The diagnostic profiles can be prepared by well-trained technicians, i.e., semiprofessional workers with a rudimentary knowledge of personality theory. These technicians, in the Kaiser project, administer the testing batteries. They supervise the scoring of the Level I and II tests. They work in teams to score the fantasy material in terms of the interpersonal variables. They perform the necessary arithmetic procedures—calculating the horizontal and vertical indices, convert-

ing them to standard scores. They plot the interpersonal scores on the diagnostic grids. They measure the discrepancies among these scores and thus determine the amount of the variability indices. They plot the variability profile.

With these two diagnostic patterns—the variability and interpersonal profiles—it is possible to classify patients in a most detailed manner. Eight interpersonal indices (at four levels) and 14–18 variability indices are available for automatic interpretation. These technicians are capable of translating this matrix of scores into statements which summarize the personality. They can report the behavior at Levels I, II, III, and V. They can indicate the amount of each variability index. A considerable mass of finely graduated information can be routinely reported for clinical or research purposes. In addition to these detailed classificatory statements, the personality profiles allow for a battery of individual predictions. Each of the eight interpersonal and the many variability indices have a set of empirical facts related to them. The Level II versus V discrepancy (self-description versus ego ideal) if high defines low self-acceptance or high motivation for treatment. This is correlated highly with entering and remaining in psychotherapy. This variability index, thus, leads to a specific clinical prediction. The other indices have similar prognostic applications.

The personality profile serves, in this way, as a precise, detailed classificatory system, and as a source for numerous specific clinical predictions. It has, however, limited explanatory value. It is also restricted because of its routine objective nature. The personality profiles are reliable—they do not involve speculation or intuition. The variability indices are ground out automatically, but they fail to integrate the complex network of scores. They do not in any way lessen the necessity for clinical, professional interpretation. They rather serve as a highly articulated assistance to the clinician.

The personality diagnostic report.[2] In the Kaiser Foundation Clinic the professional diagnostician enters the picture after the personality profiles have been plotted. All the testing, scoring, tabulating, and statistical predictive procedures are accomplished by technical workers. The task of the professional clinicians is to weave the multidimensional pattern of scores and probability statements into a unique, meaningful summary which fits a particular patient. This is accomplished by means of the personality diagnostic report.

The main task of the diagnostic classifications is to categorize reliably. The profiles provide a long list of standardized probability

[2] A sample diagnostic report written about an illustrative patient is contained in Appendix 4.

statements. The diagnostic report has the function of explaining the personality. The clinician studies all aspects of the interpersonal profile and relates them to the case.

The intake worker's notes on family history are compared with the patient's view of mother, father, and spouse—and with his fantasy images. The indices of motivation and prognosis are compared with the patient's symptomatic presentation. All the available clinical data are reviewed in light of the personality profiles and indices. In this way, the experience of the clinician is brought to bear on the evaluation process. The thousandfold, multifaceted pattern of the patient's situation can be assembled in the mind of the professional worker.

The diagnostic evaluation and the predictions are, of course, increased in efficiency as the clinical material qualifies and amplifies the conclusions of the more routinized profiles. The diagnostic report allows room for the creativity and insight which no systematic schema can duplicate. The profiles are, of course, analogous to the laboratory and radiological indices provided to the medical diagnostician. The final diagnosis and prescription is based on the multiple correlation procedure of great complexity which takes place in the mind of the professional worker.

The diagnostic report deals with such a vast array of cues—clinical and systematic—that it is highly individualized. It is less reliable than the classification and profile ratings. It has a margin of unreliability which must be hazarded because of the complexity of the subject matter.

From the research standpoint, the personality report possesses a great value. The correlations and results by which we test yesterday's hypotheses are provided by the objective indices of the interpersonal and variability profiles. In our scientific validation procedures we do not rely on the intuitive personality report for proof. The qualitative clinical report has, however, an inestimable research value because it produces the hypotheses of tomorrow. Scientific progress in personality psychology works upward from the clinical, creative speculations which are first expressed in the personality reports. The profiles, it will be noted, serve admirably to give objective tests to hypotheses and to yield probability predictions. Their very objectivity, however, guarantees that they will never generate a new idea.

The future of personality research lies in the front lines of the functional situation. The neat predictions from the research office get dented and pushed around by the rough pressure of human individuality. We know very well that the indices do not take into account the familial, occupational, cultural, or educational history of the patients for whom they attempt to predict. At exactly the spots where the

TABLE 6

THREE ELEMENTS OF DIAGNOSIS OF PERSONALITY: CLASSIFICATION, PROFILES, AND REPORT

	Executed by	*Reliability*	*Manner in Which Predictions Are Produced*	*Diagnostic Function*	*Prognostic Function*	*Creative Function*
Diagnostic Classification of Personality	Clerk	Almost complete accuracy and perfect reliability	Reading location on diagnostic grids and summary profiles	General categorization of personality type	Broad prediction for groups	Creativity is built into the system and is out of the hands of the user
Diagnostic Profiles of Personality	Technician	Known accuracy and reliability	Plotting specific indices and consulting tables of predictions	Specific categorization of detailed aspects of personality structure	Specific probability predictions for individuals	Creativity is built into the system; complexity allows some limited room for re-interpretation
Diagnostic Personality Report	Professional clinical worker	Hazarded unreliability	Intuitive integration of systematic predictions, indices, and clinical summary	Detailed summary of unique pattern of the individual	Explanatory function	Creativity is in hands of interpreter; freedom for new theory and new hypotheses

predictive indices fail, the clinician is present to observe and to integrate. If the predictions hit an accuracy of 90 per cent they still fail on ten patients in every hundred. Each ten failures may be related to new clinical variables which may later be added to the system, recast in operational language, and tested for validity. Inaccurate predictions are not embarrassments but sources of new hypotheses.

All three elements of diagnosis—the classification, the profiles, and the report—are necessary for optimal evaluation of personality. Each has its limitations—each makes its unique contribution to the clinical and research aspects of the science. Many problems and frictions in psychology might be lessened if the nature and function of these three elements is kept straight. Table 6 presents a summary of these three types of diagnostic procedures which are now employed in the Kaiser Foundation project.

Functional Diagnosis

The evaluation of personality which we are describing in this book is called functional diagnosis. The aim of our measurements is to understand the *patient-in-his-relationship-to-the-clinic* and to make predictions about the *patient-in-relationship-to-his-future-therapist.* The focus of our diagnostic observations is the interpersonal behavior in the context in which we (the clinical staff) have commerce with him. The results of a psychological test battery can be studied from many vantage points. It is possible for psychologists to predict competence in combat flying, academic success in college, occupational fitness, etc. These predictions may, in certain situations (in the air force, on the campus, in the factory), be quite functional and relevant. They would not be much help to the psychiatrist attempting to decide the best plan of psychotherapy.

Psychologists often use clinical tests to estimate the patient's *creativity*, *constriction*, *impulsivity*, etc. These findings have some value in the understanding of personality, but they would be of little use to the clinician who wants to know: "Why is this patient coming to the clinic? How much and what kind of motivation is present? How will he react to different types of treatment?"

Other psychologists are able to outline with impressive sophistication the probable genetic history of the patient, the early traumatic events, and the finely detailed nuances of the patient's sexual adjustment. For patients who enter psychoanalysis or long-term treatment these predictions undoubtedly point ahead to materials which will emerge in the associative content. The Kaiser Foundation project has not attempted to measure these areas of personality—partly because they are beyond the scope of our technical capacity, and partly be-

cause we believe them to be less functional in regard to the crucial aspects of pretherapy planning and of therapeutic interaction.

The first aim of functional diagnosis is to summarize before treatment the aspects of the personality which have a bearing on the choice of treatment. What is the motivation of the patient in coming to the clinic? Does he come with self-depreciation, ready to unburden his innermost thoughts and expecting some kind of mystical cure to follow his confidences? Disappointment and bitter reproach may be the easily predicted outcome if this motivation is not perceived and planned for. Does he come under pressure from someone else (e.g., a physician), defensively mobilized against any self-examination? A stubborn power struggle and angry departure may be predicted if this motivation is not recognized and responded to.

Clinical diagnosis concerns ego factors which influence the choice of treatment. How much anxiety is manifested? What are the security operations by which the patient handles anxiety? What is the interpersonal pressure put by the patient on the clinic?

The first aim of functional diagnosis is, then, to assess motivation for treatment. The second aim is prognosis of treatment—to summarize the kind of behavior which will appear in future therapy. How fast or slow will be the course of therapy? Many patients who are well motivated for change (thus satisfying the first criterion of functional diagnosis) also manifest chronic, deeply rooted security operations which are most resistant to change, or underlying psychotic distrust which had best be left unexplored.

Another aspect of prognosis concerns the nature of the intrapsychic conflicts. In many cases it is possible to point to private or "preconscious" motives which will probably affect the later treatment relationship. A different transference relationship and prognosis are indicated depending on whether the underlying themes involve distrustful, passive resistance, or independent autonomy, or nurturant tenderness.

In making our prediction about the first (or motivational) aspect of functional diagnosis we are mainly interested in "ego" factors. In making the second prediction we concentrate on the deeper, "preconscious" aspects of personality and their relationship to the more overt or public factors. We use the total interpersonal profile to map out areas of anxiety, the security operations by which it is handled, and the transference phenomenon which they will tend to elicit during psychotherapy.

Interpersonal Typology

To accomplish functional diagnosis the total personality pattern (both the interpersonal and variability profiles) is employed. In-

volved in this total matrix are thousands of individual measurements which are summarized in terms of sixteen interpersonal diagnostic circles and an extensive assortment of variability indices. The complexity of this system of diagnosis is such that it is almost impossible that any two patients would ever show exactly the same kind of multilevel profile.

For this reason a typological system is needed. Methods have been developed for summary classification of interpersonal and variability types. In this chapter we shall consider the interpersonal typology.[3]

Two Kinds of Interpersonal Typologies. We recall that interpersonal behavior has been rated at five levels. Two of these—Level I communication and Level II self-description—are considered to refer to the overt picture which the patient expresses in the clinical situation. These are designated *presenting operations*. A technique has been worked out for typing or categorizing the more overt, conscious aspects of the patient's personality. We shall speak, for example, of the *managerial* type or the *overconventional* personality.

The categories which serve to summarize these behavioral operations do not directly apply to the underlying motives of the patient. The "preconscious" themes of Level III tend to require a different typological language. In an earlier chapter we have noted that subjects in their fantasy themes express motives which are more intense and extreme than those which they manifest in their overt behavior or conscious self-descriptions. For this reason it is necessary to develop a typology for summarizing the *underlying operations* of the patient. The presenting operations (of Levels I and II) are, therefore, summarized in terms of behavioral types, and the underlying operations are categorized in terms of thematic motives. The specific diagnostic classes of these two aspects of personality will now be presented.

Interpersonal Diagnosis of Presenting Operations. The first goal of interpersonal diagnosis is to summarize the overt behavioral impact of the patient upon the clinic. The task here is to determine: (1) the kind of security operations, (2) the adaptive or maladaptive pattern of conflict. This is accomplished as follows. First, the Level II Self and the Level I symptomatic scores are converted into horizontal and vertical indices and plotted on the diagnostic grid.[4]

These summary placements, it will be noted, reflect two aspects of the Level I and II behaviors. The sector of the circle tells us *what* interpersonal operations are involved, and the distance from the center

[3] The variability dimension of personality is discussed briefly in Chapter 13.

[4] The methodology for converting conscious self-descriptions and "symptomatic communications" into horizontal and vertical indices and for plotting these indices on the diagnostic grid has been explained in earlier chapters.

tells us how extreme or intense they are. Figure 26 presents an illustrative diagraming of the Level I-M and II-C scores for an overconventional patient. Both the Level I-M and II-C scores fall in the M sector of the circle, and both fall in the outer ring of the circle, indicating that they are more than one sigma above the mean in the direc-

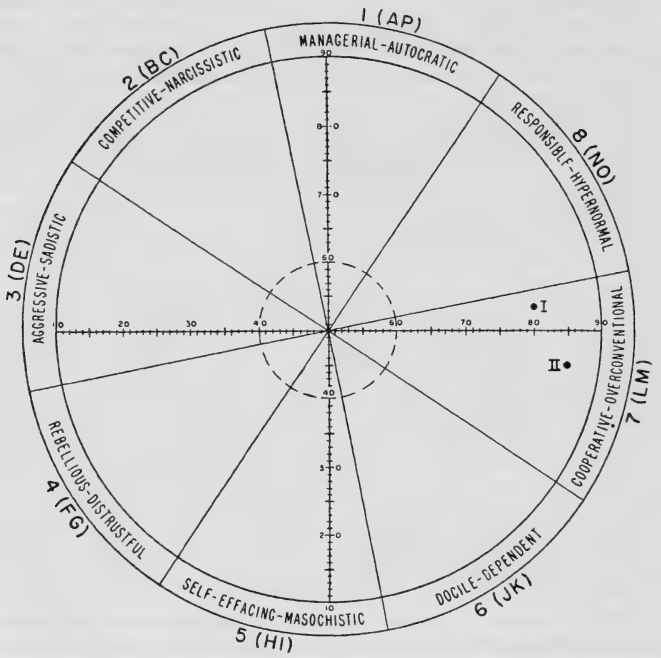


FIGURE 26. The Summary Placements of the Level I-M and II-C Scores for an Overconventional Patient. *Key:* The center of the grid is determined by the intersection of the means of the horizontal and vertical distributions. The grid is calibrated in standard score units.

tion of conventionality and blandness. Two typological procedures allow us to classify this pattern. The first step is to summarize the sixteen-variable matrix into eight diagnostic categories. This is accomplished by combining adjacent variables and assigning a descriptive term which reflects the interpersonal meaning. Pairing the sixteen variables yields eight sectors of the diagnostic circle, which are called *octants*. Thus we combine *A* (forceful dominance) with *P* (respected

success) into a power octant, and we combine *B* (self-confident independence) with *C* (competitive self-seeking) into a narcissistic octant.

We also express in our diagnostic summaries the adjustive or maladjustive aspects of the presenting operations. If the subject's behavior falls in the outer ring of the circle (one sigma above the mean), an intense or maladaptive degree of this interpersonal behavior is indicated If his security operations fall within one sigma of the center of the circle, a moderate, adaptive degree is indicated. A statistical technique for diagnosing normality-abnormality or adaption-maladaption in terms of degree is thus available. Figure 27 presents a schematic

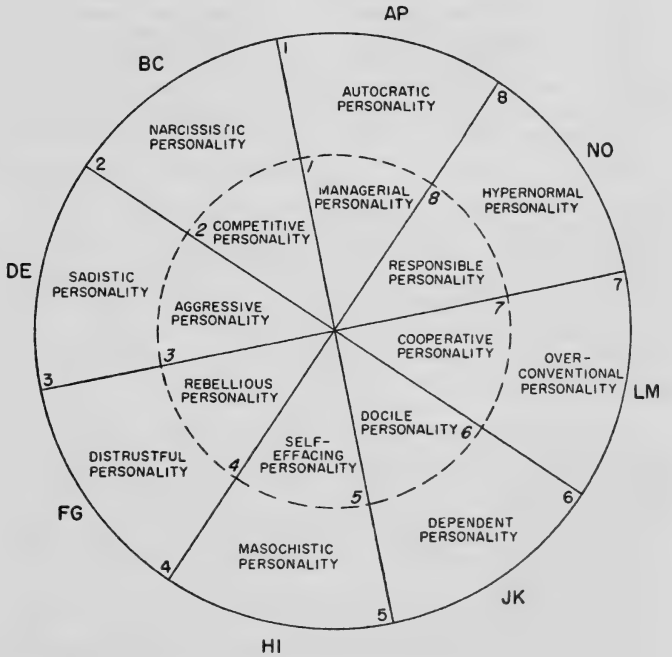


FIGURE 27. The Diagnosis of Interpersonal Behavior at Levels I and II.

illustration of this method of interpersonal diagnosis and illustrates the fact that there are eight interpersonal diagnostic categories by which we summarize the overt behavioral presentation of the patient and that

there is an adaptive and a maladaptive degree to each type. These eight adjustive and maladjustive categories are formally listed in Table 7.

TABLE 7

THE ADAPTIVE AND MALADAPTIVE INTERPERSONAL DIAGNOSTIC TYPES

Interpersonal Variable Code	*The Adjustive Interpersonal Types (one sigma or less from the mean) and the Numerical Code Used to Designate Them.*	*The Maladjustive Interpersonal Types (one sigma above the mean) and the Numerical Codes Used to Designate Them.*
AP	*1* Managerial personality	1 Autocratic personality
BC	*2* Competitive personality	2 Narcissistic personality
DE	*3* Aggressive personality	3 Sadistic personality
FG	*4* Rebellious personality	4 Distrustful personality
HI	*5* Self-effacing personality	5 Masochistic personality
JK	*6* Docile personality	6 Dependent personality
LM	7 Cooperative personality	7 Overconventional personality
NO	*8* Responsible personality	8 Hypernormal personality

It will be noted that for each adaptive and maladaptive type there is a verbal descriptive category (e.g., conventional; overconventional) and a numerical code. The numerical designation for the conventional type is 7, and for the overconventional type it is 7. The numerical index is a most convenient way of summarizing behavior at any level because the digits can be combined into diagnostic formulas. An italic diagnostic digit always refers to the moderate amount of the interpersonal trait. A roman-face diagnostic digit always refers to the intense or extreme amount of the behavior. This system of numerical code diagnosis will be discussed in later sections of this chapter.

These diagnostic terms are employed to summarize security operations at Levels I and II. The diagnosis is accomplished automatically by locating the indices for Level I in the correct octant sector and selecting the interpersonal term which reflects this particular behavior. This yields the Level I diagnosis. The same procedure is followed for Level II—the indices determine the proper sector, and the appropriate term is thus determined.

A printed booklet for deriving a multilevel interpersonal diagnosis is presented in Appendix 4.

Figure 28 presents an illustration of Level I and Level II diagnosis for two sample patients.

The Level I-M scores for patient "X" fall within one sigma of the mean of the *NO* octant. Referring to Table 7 we see that this defines an adaptive degree of responsible behavior. Patient "X" is therefore diagnosed at Level I-M as a Responsible Personality (numerical code

diagnosis = *8*). The Level II-C score for this patient is in the same octant but beyond the normal range. This patient is self-diagnosed as a Hypernormal Personality (numerical code diagnosis = 8). For routine diagnostic research categorization of what we have called "presenting operations," the Level I and II diagnostic terms can be combined in a hyphenated designation, which for patient "X" would be Responsible-Hypernormal Personality. A more convenient summary method is to combine the numerical codes, which for patient "X" would be *8*8. The first term (verbal or numerical) in any diagnostic formulation always refers to Level I-M symptomatic behavior, and the second term to Level II-C self-description.

The Level I-M of the other illustrative patient "Y" falls in the outer ring of the *HI* sector. This (by reference to Table 7) is seen to define a Masochistic Personality at Level I-M (numerical code diagnosis = 5). The Level II-C scores fall in the extreme end of the *JK* octant. The Level II-C diagnosis is: Dependent Personality (numerical code diagnosis = 6). The combined diagnosis of presenting operations is Masochistic-Dependent personality, or more simply a "56" personality type.

In practice, the single level diagnosis is rarely employed. The focus of the functional diagnosis generally includes the combined presenting operations of Level I-M plus Level II-C. There are sixteen possible categories for diagnosis at Level I-M—eight adjustive and eight maladjustive types. The same number of categories are available for summarizing Level II-C behavior when we turn to the combined diagnosis involved in the presenting operations. There are, therefore, 256 categories for interpersonal diagnosis of presenting, or facade operations.

To present a diagnostic system involving 256 types would seem to be an audacious gesture, placing an impossible task on the diagnostician who attempts to use this system. It has already been pointed out that diagnosis in the interpersonal system is a most routine and undemanding procedure. What we ask of a diagnostic label is an objective summary categorization for administrative or research classificatory purposes. We do not ask our diagnosis to take the place of a personality profile or a personality description. It is, instead, an automatic and reliable classification. In practice, the interpersonal diagnosis is routinely determined by clerical procedures. The patient's scores on Levels I and II are placed on the diagnostic grid, and the appropriate diagnostic terms or two-digit diagnostic codes are automatically determined. The theory and methodology of the interpersonal system is complex, but the employment of the system for the purpose of diagnostic classification is simple.

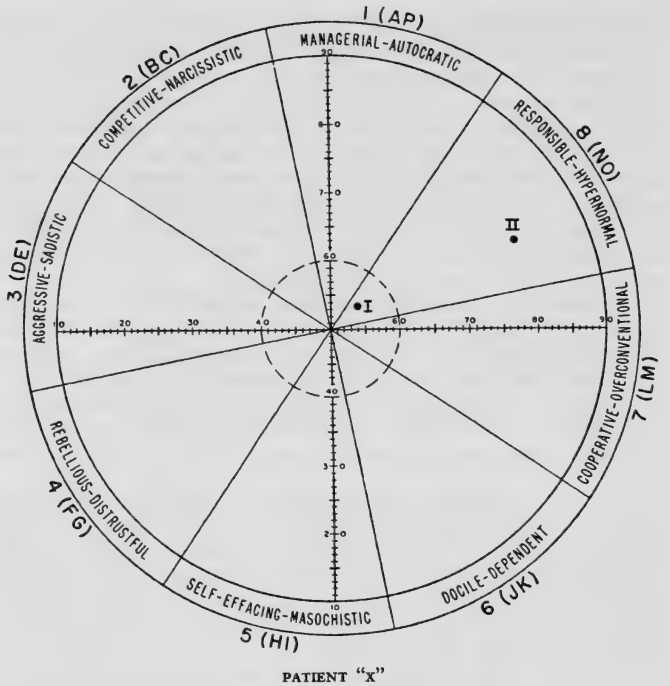


FIGURE 28. Illustration of Interpersonal Diagnosis at Levels I-M and II-C for Two Patients, "X" and "Y" (*see facing page*).

INTERPERSONAL DIAGNOSIS OF "UNDERLYING OPERATIONS." The second goal of functional diagnosis is, we recall, to summarize the thematic "preconscious" motifs, to relate them to the overt presenting operations, and to employ these data to make predictions about the future course of treatment. We shall now consider a method for summarizing the "preconscious" themes of Level III.

The theory and measurement methods for Level III fantasy expressions were presented in Chapter 9. It was emphasized that there are two layers of "preconscious" data—the themes assigned to fantasy heroes and those assigned to fantasy "others." These sublevels involve different psychological functions. They have different lawful relationships with the other aspects of personality structure. These two

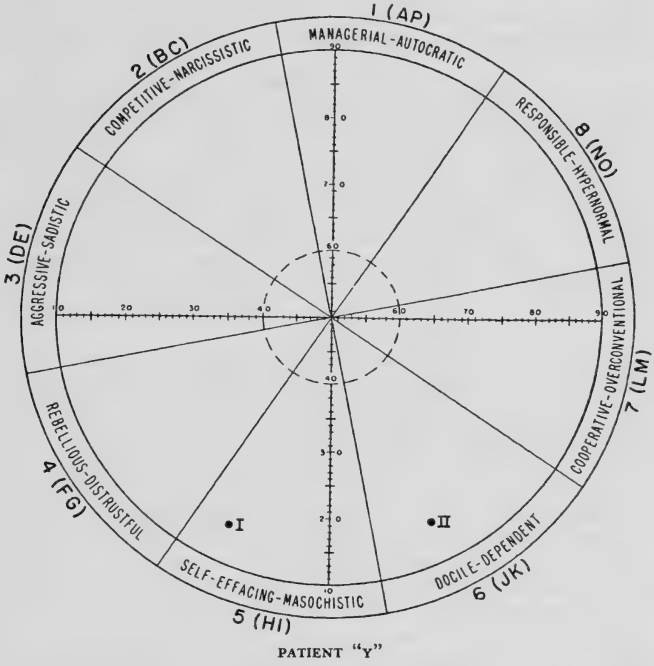


FIGURE 28 (*cont.*)

sublevels provide two diagnostic types of underlying operations.

In Chapter 9 we presented a method of measuring the interpersonal themes from fantasy data and for converting the resulting scores into indices which locate the subject on the diagnostic grids for Level III-T Hero and Level III-T Other. There remains the task of formally dividing the Level III-T grids into summary diagnostic sectors. This is accomplished in the same manner as for Levels I-M and II-C. The sixteen-variable matrix is combined into the same eight sectors and the appropriate descriptive terms or numerical codes assigned. The Level III diagnostic circle is presented in Figure 29.

In comparing the diagnostic grid for Level III with that used for Levels I and II, two differences will be observed. The first concerns terminology—Level III deals with underlying private motives and not behavioral manifestations. The diagnostic terms tend, therefore, to reflect general motivational purposes rather than social role be-

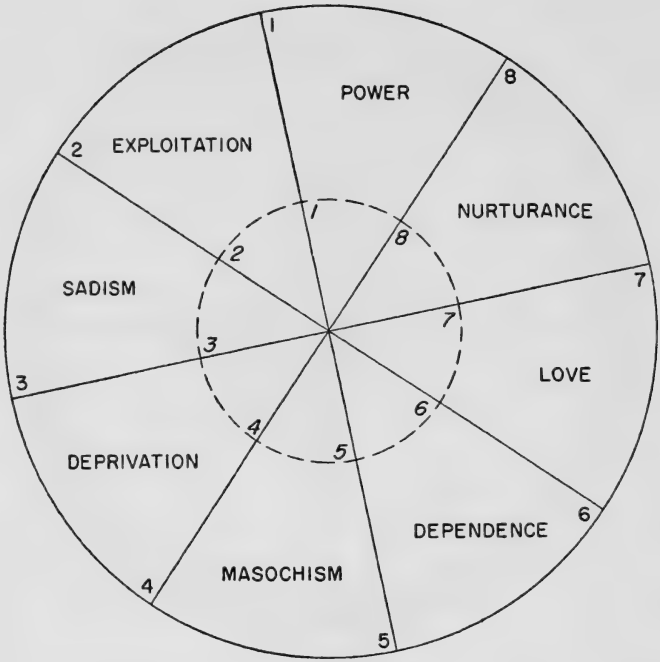


FIGURE 29. The Diagnosis of Interpersonal Behavior at Level III Hero and Other.

havior. A second difference concerns the degree of intensity. At Levels I and II we distinguish between adaptive behavior and maladaptive extremes. At Level III no such distinction is maintained in setting up verbal descriptive categories. There are two reasons: Theoretically it is questionable that "preconscious" imagery can be conceptualized as being adaptive or maladaptive. In one sense it appears that this differentiation violates the notion of the equilibrium or "safety valve" function of fantasy. In some cases the most violent and antisocial autism may serve a healthy balancing function. The second reason for not making the adaptive-maladaptive distinction at Level III tends to make the first argument academic. At this point our measures of Level III fantasy are so crude and preliminary that the fine distinctions of normal versus abnormal autisms have been difficult to study. The distinction between italicized numerical digits (for

moderate behavior) and roman-face digits (for intense behavior) is maintained at Level III, but it simply reflects the amount of the interpersonal emotion.

There are, then, eight verbal summary categories and sixteen numerical categories for diagnosing behavior at Level III Hero and Other. We have been continually reminded by one of the basic mottoes of this book that no level has meaning by itself, and each level must be interpreted in light of the other levels. Some theories of personality do tend to diagnose on the basis of underlying motives. The Kaiser Foundation system, on the contrary, does not follow this procedure. We may tend to overemphasize the presenting operations (i.e., diagnosing from Levels I and II), but complete diagnosis includes the underlying thematic behavior.

MULTILEVEL INTERPERSONAL DIAGNOSIS. We are now ready to proceed to the complete interpersonal diagnosis of the two sample cases whose behavior we have been considering in this chapter. *Interpersonal diagnosis is accomplished by combining the summary descriptive terms for Self behavior at Levels I and II, and the Self and Other behavior at Level III. The significant omissions of Level IV, and the behaviors of "others" at all levels (except III), and the value-themes of Level V are not included in the diagnostic categorization.* It must also be kept in mind that we are dealing, in this chapter, with the interpersonal aspects of diagnosis. The variability diagnosis, which comprises the other half of functional diagnosis, will be treated in Chapter 13.

Figure 30 presents the Self scores of two patients, "X" and "Y," at the three levels (I-M, II-C, and III-T) which comprise interpersonal diagnosis. The methodology for plotting the summary scores on the diagnostic grid has already been described. The diagnostic classification is automatically obtained from Table 7 (for the Level I-M and II-C terms) and Figure 30 (for the Level III terms). The Level I-M score for patient "X" falls in the adaptive ring of the *NO* octant (numerical code = *8*), his Level II-C score in the maladaptive range of the same octant (numerical code = 8), the Level III-T Hero and Other scores in the *DE* octant (both coded 3). His interpersonal diagnosis is: *responsible-hypernormal personality with underlying hostile feelings.* The four digit diagnostic code is *8*833.

The Level I-M and II-C scores for Patient "Y" fall in the maladaptive ring of sectors *FG* and *JK* respectively (coded 46). The "preconscious" Hero scores are in the outer ring of the *BC* octant (coded 2) and the "preconscious" Other scores are in the inner ring of the *HI* octant (coded *5*). Referring to Table 7 (for the Level I

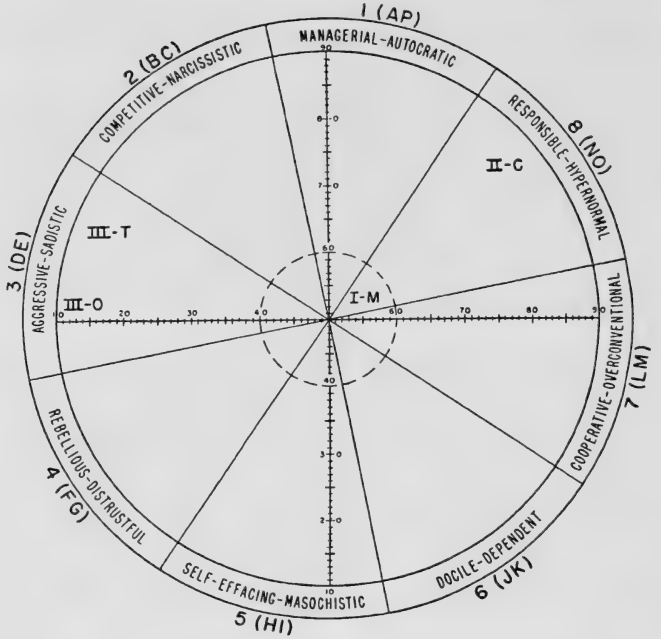
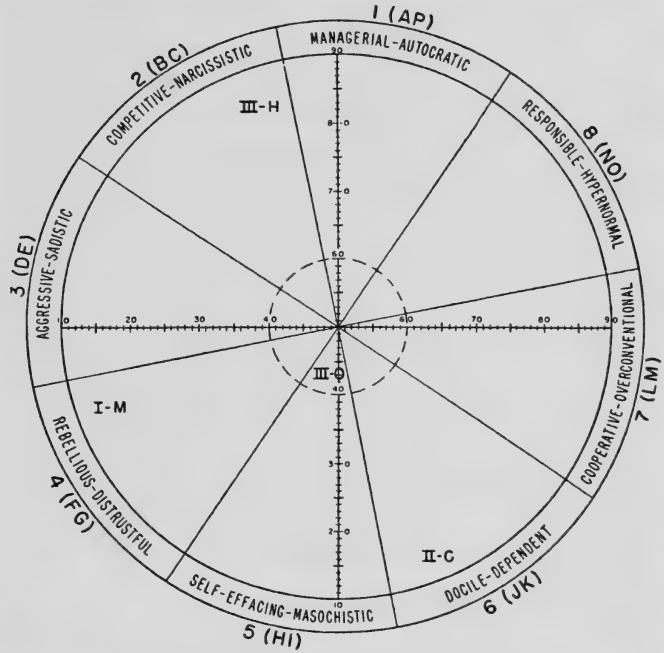


FIGURE 30. Illustration of Interpersonal Diagnosis at Levels I-M, II-C and III-T for Two Patients ("X" and "Y"). *Key:* For Levels I-M and II-C the circular dotted line indicates the distance of one standard deviation from the mean. (The mean for both the horizontal and vertical distributions in the center of the circle.) At Levels I-M and II-C scores falling within the inner circle are considered adaptive and those in the outer circle maladaptive. At Level III-T the verbal distinction between adaptive-maladaptive is not maintained. Figure 29 presents the interpersonal diagnostic categories for Level III.

and II terms) and Figure 29 (for the Level III terms), we see that his interpersonal diagnosis is: *distrustful-dependent personality with underlying narcissism and deeper feelings of masochism.* The diagnostic code for this four-layer pattern is 5625.

The verbal diagnostic formula comprises a four-part sequence. The Level I diagnosis comes first, and it is always paired with the Level II diagnosis. The hyphenated description summarizes the presenting operations of the patient. The Level III Hero and Other diagnoses fol-



PATIENT "Y"

FIGURE 30 (*cont.*)

low. The standard grammatical structure of an interpersonal diagnosis can now be considered:

"_____-_____ PERSONALITY WITH UNDERLYING _____, AND DEEPER FEELINGS OF _____."

The first two elements, "_____-_____ personality," are determined by the Level I and II summary scores. The third element in the diagnostic formula, "with underlying _____," is obtained from the Level III Hero summary scores. The fourth element comes from the Level III Other indices. To complete the functional diagnosis we add the variability diagnosis.

THE NUMERICAL DIAGNOSTIC CODE. The numerical diagnostic summary is a four-digit formula which sequentially presents the Level I, II, III Hero, and III Other scores.

This four-layer system of interpersonal diagnosis provides an objective, reliable, and standardized classification. The diagnostic formula summarizes the four aspects of the patient's security operations which are most central to the decisions which clinicians make about patients: How does he act? How does he see himself? What are his underlying interpersonal potentials?

A detailed and complex diagnosis is involved in the four-layer formula. It was pointed out that there are 256 types of presenting operations. Each of these 256 diagnostic types can be characterized by any one of eight Level III Hero patterns and by any one of eight Level III Other patterns. For example, the patient whose presenting operations are diagnosed "responsible-hypernormal" can have underlying "preconscious" themes located in any of the eight Level III Hero sectors and in any one of the eight Level III Other sectors. There are 64 combinations of Level III Hero and Other scores. There are, therefore, 16,384 (256×64) verbal diagnostic formulas available for summarizing human security operations. When we consider the four-layer combination of numerical codes, a much larger set of possibilities exists. It will be recalled that the distinction between moderate and extreme behaviors is preserved in numerical diagnosis, italic numbers referring to the former and roman-face numbers to the latter. There are, therefore, 65,536 ($256 \times 16 \times 16$) numerical formulas available for summarizing interpersonal behavior at four layers of personality.

Of the 16,384 verbal diagnostic categories, one quarter characterize the adaptive or adjusted personality (at the level of presenting operations). One quarter of them involve maladaptive types. One half of them designate personalities who have inconsistent ratings of adjustment-maladjustment. Of this latter group it is obvious, by definition, that half of them are self-diagnosed as adaptive in the context of a symptomatic (Level I) diagnosis of maladjustment, while the other half of this mixed group are self-diagnosed as maladjusted in the context of a clinical symptomatic rating of adjustment.

Each of these four broad categories has an obvious clinical and theoretical meaning. A diagnostic formula is, of course, a crude and rough estimate of the security operations of the individuals, and it in no way can be substituted for the more detailed pattern obtained from the interpersonal and variability profiles or from the personality report. With this qualification in mind, it can be seen that a specific multilevel diagnosis (of the sort we have just presented) provides a useful core of relevant information. In one standardized four-digit formula we obtain a summary of (1) the interpersonal behavior at three levels and (2) an estimate of kind and degree of adjustment-maladjustment.

The Relationship of Interpersonal Diagnosis to Pyschiatric (Kraepelinian) Diagnosis

In an earlier chapter it seemed pertinent to comment on the problems created by the novelty of the interpersonal system. When the reader who has struggled to acquaint himself with sixteen variables, five levels, fourteen variability indices is now presented with 16,384 verbal diagnostic types or 65,536 diagnostic codes, the proliferation of new terms and concepts may seem to be getting out of hand. At this point it may prove encouraging to point out that the interpersonal diagnostic system is not completely divorced from the traditional language of the clinic. In our diagnostic formulations we employ a behavioristic and interpersonal language to summarize the patient's personality. We are often called upon to communicate our diagnoses to other clinicians who are not familiar with the systematic language of the interpersonal system.

The interpersonal language—masochistic, autocratic, etc.—has the advantage of a narrow and parochial usage. The Kraepelinians' diagnostic language, by comparison, possesses an almost universal popularity of usage, but is often vague and unclear. Most every clinician tends to use labels such as *schizoid* or *hysteric*, but many of them mean quite different things by these terms. One clinician may conceive of the hysteric in terms of certain colorful symptoms; another may refer to the state of psychosexual development; another may denote a certain pattern of repressive defenses when he employs the term.

However obvious its drawbacks, the Kraepelinian nosology has two irrefutable claims to survival—its widespread acceptance and its implicit connotations. A great deal of wisdom has accumulated in the folklore of psychiatry. By this we mean that a psychiatric label (e.g., *hysteric*) is a crude, disorganized synthesis of many variables of behavior. Some of these are inconsistent, some subjective to the user, some tautological, some unimportant, some valuable. Further, it seems safe to say that most psychiatric labels have some interpersonal factor loading. Schizoids show different interpersonal behavior from hysterics, or from phobics, or from obsessives. It follows, therefore, that there must be considerable overlap between the standard Kraepelinian nosology and the interpersonal diagnostic system presented in this chapter.

With this hypothesis in mind an investigation of the interpersonal factors in psychiatric terminology was undertaken by the Kaiser Foundation research project. If this hypothesis is true, then several advantages will accrue to both diagnostic systems. The objectivity,

reliability, and systematic complexity of the interpersonal schema can be related to the standard Kraepelinian terminology. The latter might be partially defined in terms of the operational language of the former. The pathological, maladjustive emphasis of the Kraepelinian system may be amplified by the adaptive dimensions of the interpersonal schema.

Testing the Relationship Between Interpersonal and Psychiatric Diagnosis

The question now posed might be worded as follows: What is the relation between interpersonal and standard psychiatric diagnosis? The preceding sections of this chapter have presented a method for establishing interpersonal diagnosis at three levels (four sublevels) of personality. For comparison with Kraepelinian categories it seemed logical to employ the levels which define presenting operations, i.e., Levels I and II. For the exploratory investigations it was decided to use the Level II self-description as the interpersonal diagnostic criterion. The obtaining of an index of interpersonal diagnosis was, thus, a single straightforward task. The next problem was to find a measurement or rating of Kraepelinian diagnosis to compare with the interpersonal criterion. This was not as easy a procedure. The most obvious solution was to ask psychiatric clinicians to make diagnostic judgments of the same patients where Level II profiles were employed for interpersonal diagnosis. This proved to be unfeasible for two reasons. In the first place, psychiatric diagnostic judgments are notoriously unreliable (1, 2, 3, 5). If one side of the comparison is an undependable measure, the extent of the true relationship between the variables is clouded. A second disadvantage of clinical diagnostic ratings concerns the subjective factors unique to each clinician. Extended conversations with practicing clinicians revealed a wide variation in individual preferences for use or avoidance of certain Kraepelinian terms. Some psychiatrists expressed doubt as to their ability to employ certain diagnostic categories satisfactorily. Others believed that pure Kraepelinian types were rare, and that most patients show a mixture of reactions. Most all of them expressed a preference for dynamic or psychoanalytic language.

The search for a criterion measure of psychiatric diagnosis which would be reliable and standardized led us in the direction of psychometric estimates. The Minnesota Multiphasic Personality Inventory seemed to be a most satisfactory estimate of psychiatric diagnosis because it is reliable and because there are widely accepted patterns of scores which are valid estimates of psychiatric diagnosis.

The comparison procedure can be briefly summarized as follows. The MMPI diagnosis of 200 clinic patients was determined (by pooled ratings of three psychologists).

Six of the most common neurotic types or character disorders were employed as the diagnostic criterion. The Level II diagnoses of these same patients were obtained. The results are summarized in Table 8. They indicate that these six psychiatric diagnostic types are related to different interpersonal modes of behavior.

TABLE 8

MEDIAN INTERPERSONAL SELF-DESCRIPTION SCORE FOR SIX MMPI CLINICAL GROUPS

Psychiatric Diagnosis	*MMPI Sorting Criteria*	*Number of Cases*	*Median Score on Level II Interpersonal Continuum*	*Verbal Summary of Level II Score*
Psychopathic	F, Pd, Ma	12	*D*	Aggressive, sadistic
Schizoid	D, F, Sc, Pd	32	*F*	Bitter, distrustful
Obsessive	D, Pt	42	*H*	Self-derogatory, passive
Phobic	D, Pt, Hy	48	*K*	Docile, dependent
Hysteric	Hy, K	31	*M*	Bland, overconventional
Psychosomatic	Hs, Hy	35	*M-N*	Responsible, hypernormal, generous

Patients who employ aggressive, nonconventional modes of maladjustment tend to obtain the psychiatric diagnosis of psychopathic personality. Distrustful, passively-resistant modes of adjustment tend to be called schizoid; submissive, self-punishing patients tend to be called obsessives; docile, dependent patients tend to be labeled phobics; bland, naïve, overconforming patients tend to be diagnosed hysterics; and responsible, hypernormal patients fit the psychosomatic pattern of the MMPI.

Of the eight interpersonal modes of adjustment-maladjustment, six are related to psychiatric categories. Two interpersonal modes, however, the autocratic-managerial and the competitive-narcissistic, seem to have no psychiatric equivalent. A new question arises: Why do two interpersonal modes fail to merit psychiatric diagnostic categories? Why do managerial and competitive people fail to excite diagnostic attention, and thus avoid formal psychiatric recognition? These categories are not unmentioned in the clinical literature. Exploitive, narcissistic, power-oriented techniques have been described by Fromm, Horney, and Sullivan. Prior to these culturally oriented writers little reference has been made to these cases. They have not obtained nosological popularity in any formal diagnostic system.

We are led to speculate that these types have received little diagnostic attention because they do not come for help. Perhaps they do not seek therapeutic assistance because the very essence of these maladjustments is a compulsive maintenance of autonomy, independence, and domination. These social techniques clearly preclude the role of a psychiatric patient.

Our personality theories have generally been grounded in clinical practice. But there seems to be increasing evidence that major neurotic groups exist which are exposed to psychological testing diagnosis and therapy in disproportionately small numbers.

Interpersonal Diagnosis. The data and speculations just presented have encouraged the possibility of relating interpersonal and psychiatric diagnoses. It now seems feasible and profitable to define psychiatric diagnoses in terms of the interpersonal expressions of the patient. In this manner we preserve the values inherent in psychiatric diagnosis, its widespread acceptance, and its statistical, administrative, and theoretical advantages, which would be lost by a total rejection of classical terminology. For these reasons the Kaiser Foundation research project has retained the older clinical categories, combining them with, and defining them in terms of, interpersonal factors.

Table 9 presents the eight modes of interpersonal adjustment and maladjustment and the suggested psychiatric categories to which they may be linked. Under each interpersonal category we have listed not one trait, but a syndrome of behaviors which are most typical, and which often seem to go together. The category *HI* actually includes many normal responses—retiring modesty, thoughtful reserve, sensitive, deferent self-appraisal, etc. The same *HI* sector of the circle also includes an assortment of extreme, maladjustive reactions—passive withdrawal, ruminative immobilization, submission, and self-punitive attitudes. A variety of psychiatric terms seems to be related to this generic interpersonal mode. Patients who fall in this area of the diagnostic circle are often clinically labeled masochistic, guilt-ridden, obsessive, or psychasthenic. This cluster of psychiatric terms is thus related to the interpersonal mode. Wherever syndromes of psychiatric categories or parallel diagnostic terms exist, they are included in Table 9.

The relationships presented in Table 9 mark an important step in the segmental development of this book. They establish an important linkage between systematic interpersonal language and standard clinical terminology. They relate the standard categories of psychopathology to a continuum of maladjustive and (theoretically more important) adjustment types.

TABLE 9

OPERATIONAL REDEFINITION OF PSYCHIATRIC CATEGORIES IN TERMS OF INTERPERSONAL OPERATIONS

*Numerical Code**	*Variable Code*	*Interpersonal Mode of Adjustment*	*Interpersonal Type of Maladjustment*	*Standard Psychiatric Equivalent of Interpersonal Type of Maladjustment*
1	*AP*	Executive, forceful, respected personality	Managing, autocratic, power-oriented personality	No psychiatric equivalent (Compulsive personality[2])
2	*BC*	Independent, competitive personality	Narcissistic, exploitive personality	No psychiatric equivalent (Counterphobic[2] Manic[2])
3	*DE*	Blunt, frank, critical, unconventional personality	Aggressive, sadistic personality	Psychopathic, sadistic personality
4	*FG*	Realistic, skeptical personality	Passively resistant, bitter, distrustful personality	Schizoid personality
5	*HI*	Modest, sensitive personality	Passive, submissive, self-punishing, masochistic personality	Masochistic, psychasthenic, obsessive personality
6	*JK*	Respectful, trustful personality	Docile, dependent personality	Neurasthenic, mixed neurosis, anxiety neurosis, anxiety hysteria, phobic personality
7	*LM*	Bland, conventional, friendly, agreeable personality	Naive, sweet, overconventional personality	Hysterical personality
8	*NO*	Popular, responsible personality	Hypernormal, hyperpopular, compulsively generous personality	Psychosomatic personality

* The numerical codes for interpersonal diagnosis also designate adaptive or maladaptive intensity. Numbers in roman face refer to extreme maladjusted interpersonal behavior and italicized numbers denote an adjustive mode.

We define "hysteric," "phobic," and other clinical diagnostic types in terms of the presenting operations of Levels I and II. It is immediately possible to study the behavior of these diagnostic types at the other level of personality and in terms of the variability indices. How do hysterics (diagnosed at Level I-M) see their mothers, fathers, and spouses? What are the identification-disidentification indices for schizoids (diagnosed at Level I-M)? What are the Level V value-aspirations of obsessives, hysterics, etc.? What are the Level III fantasy patterns of psychosomatics? The eight clinical chapters of this book are entirely devoted to a consideration of these questions, to

a summary of these new conceptions of diagnosis, and to their validation.

Thus, in linking interpersonal terminology to psychiatric diagnoses we have facilitated a systematic investigation of many important clinical problems. It will be noted, however, that this research enterprise is based on what seems to be a rather shaky foundation—the equivalence of the Kraepelinian-type diagnosis to interpersonal patterns. An objection to this equation might point out that the relationship of MMPI diagnostic patterns to interpersonal types is far from being a convincing validation. Even though the MMPI is one of the most accepted and popular diagnostic tests, and even though it is based on carefully diagnosed criterion groups, this one test cannot be considered a satisfactory criterion of psychiatric diagnosis. This objection is well taken. This is not a satisfactory criterion—but it still stands as the best criterion. The unhappy fact is that there is no possibility of getting a watertight estimate of Kraepelinian-type diagnoses. Like so many other complex, multilevel concepts in psychiatry the diagnostic categories, because of unreliability and subjectivity of conception, possess no standard criterion value.

Five years of experience in applying the interpersonal system to clinical problems, plus the validating evidence from MMPI studies, have led to the conclusion that the relationships presented in Table 9 provide a satisfactory functional definition of these six psychiatric categories. In a later section of this book eight chapters will be devoted to the eight basic interpersonal diagnostic types. As we take up each adjustive-maladjustive mode, we shall review the literature pertaining to the psychiatric equivalents. At that time it will be suggested that the standard clinical definitions of these six Kraepelinian-type categories do involve interpersonal factors that tend to substantiate the relationships from our MMPI studies which are summarized in Table 9.

The logic of operational definition, we recall, allows the scientist to define his concepts in terms of his measurements. Because of the usefulness of psychiatric diagnostic terminology, and its implicit interpersonal connotations, it has seemed valuable to include it within the interpersonal diagnostic system. The relationships presented in Table 9 therefore stand as operational definitions of the psychiatric terms concerned (at the designated level). In the subsequent chapters we shall be employing the terms "overconventional," "dependent," etc. When they are used it will be understood that they correspond to the respective psychiatric equivalents (at Level I-M or II-C) as indicated in Table 9.

The Use of Standard Psychiatric Terms in Interpersonal Diagnosis

The Kraepelinian-type categories are taken to be synonymous for the appropriate maladjustive types. According to this system *hysteric* is a synonym for *overconventional personality*; *obsessive* can be used interchangeably with *masochistic personality*. The Kraepelinian-type terms do not interchange with the adjustive types, but only with the maladjustive types.

The new clinical terminology is employed in exactly the same manner as the interpersonal maladaptive categories. If a patient manifests extreme *LM* at Level I and extreme *FG* at Level II, he is designated in interpersonal terminology as an *overconventional-distrustful personality* (numerical code = 74). For research purposes we employ the numerical code. If we wanted to communicate with a future therapist who is familiar with the interpersonal system we would probably use the interpersonal terms. If we wanted to communicate with a conventionally trained psychiatrist who is unfamiliar with the interpersonal language we would diagnose the patient *hysterical-schizoid personality*.

Two additional considerations remain before concluding this chapter on interpersonal diagnosis. Table 9 presents the eight basic interpersonal types and lists many standard psychiatric categories which seem to relate to them. According to this system of diagnosis, phobics, neurasthenics, reactive depressives, and anxiety neurotics all can be expected to manifest docile-dependent trends. When the diagnostic label is tied to the security operations displayed by the patient, some changes in meaning and accompanying paradoxes can be expected. It is possible for a patient to exhibit a phobic or anxiety *symptom* and not the dependent behavior that we expect to go along with it. Sometimes a most aggressive or boastfully self-confident patient comes seeking psychiatric help for phobic complaints, i.e., irrational fears or anxiety reactions. We diagnose, however, on the basis of character or symptomatic pressure, not on the basis of the symptom itself. The diagnosis summarizes the presenting operations. In cases of this sort we generally find that the symptoms are a result of some threat to the overt security operations. Sometimes the underlying operations reflect the interpersonal themes that go with the symptom. Thus the patient who presents (at Levels I-M and II-C) as a counterphobic, self-satisfied person with a phobic symptom would be given the presenting diagnosis of *competitive or narcissistic personality* (22 or 22). Examination of his "preconscious" behavior might reveal fearful and dependent themes (which we have seen to be related to phobic material).

The symptom can be related to any level of personality, or it can simply reflect an environmental pressure which makes the overt security operations inadequate or inappropriate. An example might be an acute anxiety attack suffered by a compulsive, managerial personality. If the multilevel profile involves "preconscious" passivity (e.g., 1166), we might surmise that the symptom represents a leaking out of the underlying fear. If the multilevel pattern involves a solid four-layer edifice of strength and power (e.g., 1111), then the symptom would undoubtedly be a reaction to an environmental pressure for which his compulsive, managerial operations are inappropriate or inadequate. The pedantic, compulsive professor may be threatened by the loss of his job; or the bossy, self-made businessman may be threatened by the prospect of failure. Systematic diagnosis cannot, therefore, allow itself to be tied to description of symptom. The solution, we submit, is systematically to describe and summarize behavior at the levels in which it is manifested.

A final point merits comment. In looking over the list of standard psychiatric diagnostic terms to which we have given interpersonal redefinition, it will be noted that a few common categories are omitted. Among the terms which are left out of the list of maladjustments are such familiar labels as *manic-depressive*, *paranoia*, *catatonia*, etc.

These have been excluded because there seems to be no typical interpersonal pattern associated with them. The essence of these disorders is an inconsistent behavior. The emphasis, on the contrary, seems to be on the changeability of behavior. This is obviously true of the hyphenated term *manic-depressive*—the variability is the essence of the personality. The term *catatonic* (which seems, by the way, vaguely defined and diminishing in popular usage) is generally described in variability terms. *Paranoid*, however, seems on the surface to have a most clear interpersonal meaning. It is used, in fact, synonymously with the *distrustful, suspicious personality*. While not everyone would agree, we have come to the conclusion that *paranoid* is one of the most loosely defined words in the psychiatric dictionary. A brief review of its connotations will reveal its protean and paradoxical complexity. We have already mentioned its denotation of suspicion (*FG*). It also refers to delusions of grandeur (*BC*). Paranoids are generally associated with litigations, quarrelsomeness, or dangerous outbursts of aggression (*DE*). They often present themselves as pedantic and domineering (*AP*). They often claim to be hypernormal —denying pathology and weakness (*NO*). They are most frequently characterized by an obtuse, self-righteous, bland overconventionality, which Robert E. Harris has called "poignant naïveté" (*LM, JK*).

It is clear that there are a variety of specific interpersonal and

symptomatic pressures that the so-called "paranoid" puts on the clinician. In fact, it seems that the essence of the term implies a complex, unapproachable, unstable personality. Many clinicians tend to sniff out the so-called "paranoid reaction" whenever they have the uneasy sense that multiplicity (and perhaps duplicity) of motive exists in the person they are dealing with. The essence of this diagnosis might be reduced to these factors: (1) complexity and variety at the level of presentation, (2) underlying hostility and distrust (which cannot be included in the diagnostic summaries of presenting operations), and (3) duplicity and/or self-deception (i.e., discrepancy between self-perception and view of self by others). These three criteria seem to suggest that the diagnosis of paranoia revolves around a certain pattern of variability (especially conflict between presenting operations versus underlying themes, and between the two types of presenting operations [Level I-M versus Level II-C]).

For these reasons the psychiatric terms *paranoid*, *manic-depressive*, and *catatonic* are not considered as denoting interpersonal patterns of presenting operations. They seem, instead, to point to certain phenomena of changeability, conflict, cyclical oscillation, and misperception.

The Diagnostic Continuum. In the preceding section we have cited evidence relating the interpersonal types to standard psychiatric diagnoses. The interpersonal types are on a continuum in such a way that neighboring behaviors are related, and behaviors opposite on the circle are considered to be negatively related.

When we substitute psychiatric diagnostic terms for interpersonal categories we are suggesting that a diagnostic continuum exists.

The advantages of such a continuum (if valid) are considerable. The process of diagnosis can be changed from a hit-or-miss pigeonhole classification to a more systematic enterprise. The reliability and meaning of diagnosis can be increased. If one clinician using the standard nosology calls a patient an hysteric, and a second labels him as phobic, a complete diagnostic "miss" must be registered. The use of the diagnostic continuum can clarify this situation. In this illustrative situation the two diagnosticians would be considered to be in fairly close agreement since they are just one unit off in their disagreement (since hysteric is one unit removed from phobic on the continuum).

The value of this system depends, of course, on its validity. We have listed the diagnoses in a rough ordinal array. Does this make clinical, empirical sense? Are hysterics closer to phobics than they are to obsessives?

The evidence from the Kaiser Foundation research seems to confirm the hypothesis that they are. This research, however, is based on

measurements which are shallow and obviously not as broad or deep as clinical impressions.

The validity of this diagnostic continuum can be checked by the reader with clinical experience who can determine if the ordering of categories correlates with his diagnostic experience.

The meaning of the diagnostic continuum can be broken down as follows: *Psychopathic personalities* are held to be closest to schizoids. They both share the alienation and isolation from conventional behavior. The former are more active in their hostility, the latter more passive.

Schizoid personalities are also close to obsessives. They both share a pessimistic, self-derogatory attitude. The former are more bitter and distrustful, the latter are more self-derogatory and worried.

Obsessive personalities are also close to phobics. They both share a depressed, worried passivity. The former are more guilty, more aware of their emotions. The latter fail to recognize the emotional sources of their condition and are more concerned with symptoms external to their character structure.

Phobic personalities are also close to hysterics. They both share a repressive, conventional façade. They both externalize and tend to be unaware of specific interpersonal problems. The former are more fearful and worried, the latter are more bland and unworried.

The hysterical personality is also close to the psychosomatic adjustment. They both share conventional operations and claim to be unworried and sound "psychologically." The former are more aware of some symptomatic "tension"; they present physical symptoms which are directly symbolic of underlying emotions. They are also relatively more passive and conciliatory. The psychosomatic personality emphasizes more activity and hypernormal responsibility than the hysteric.

The managerial and narcissistic personality types are not usually considered standard diagnostic categories and will therefore be omitted from these comparisons.

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III

The Variability Dimension of Personality: Theory and Variables

Introduction

The Kaiser Foundation research project works within the scope of two areas of personality—the interpersonal and variability dimensions. In Part II we presented the five levels at which we measure interpersonal behavior, and a multilevel system of interpersonal diagnosis was described.

This section of the book presents an over-all view of the variability dimension and the Kaiser Foundation theory of variability.

The variables by which we measure conflict and interlevel discrepancy are called variability indices. These are the variables of personality organization—which relate behavior at different levels. Chapter 13 presents operational definitions of forty-eight indices of variability. Some of these interlevel relationships are like classic psychoanalytic defense mechanisms. These indices are described and defined because we shall be employing them in the subsequent descriptions of clinical and diagnostic types. Their detailed description, validation, and clinical applicability will not be included in this book.

Our present purpose is to outline a system of interpersonal diagnosis and the variables by which this is accomplished. Some of the research findings which involve variability indices (e.g., identification and misperception) are summarized in the diagnostic section (Chapters 14 through 23). Other descriptions and validations of variability indices have been published in scientific journals (1, 2).

The chapter to follow will, therefore, be restricted to a brief discussion of theory and a listing of the indices of variability.

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13

The Indices of Variability

The preceding pages of this book—Chapters 1 through 12—have considered the interpersonal dimension of personality. We have seen that security operations can be classified in terms of sixteen variables. We have also considered the fact that interpersonal behavior exists at different levels and that these levels may be defined in terms of the source and nature of their expression.

The interpersonal dimension has five levels. A circular continuum of variables is employed for all measures of emotional behavior. We have dealt in some detail with the measurements, meaning, and function of these five levels. In presenting this material, the levels were considered separately. The point was made repeatedly that the data from any level are most useful in relation to all the other levels. But so far we have concentrated on statements about each level in isolation, because we have had no systematic way of dealing with the dynamic interplay among levels. The time has come to discuss these relationships. We are going to fit together four[1] discrete parts of personality structure in order to build a systematic theory of personality organization. We are going to study the integration of the over-all personality. The shift in reference we make here is important to note. Up until now we have dealt with unilevel data. Now we are going to study multilevel phenomena—the dynamics of organization. It is necessary, at this point, to distinguish between statements that refer to security operations and to the arrangement of interpersonal variables at a single level or area (i.e., the circle) and those which refer to the differences among the circles. The former can be called *class* (i.e., unilevel) statements and the latter *relationship* (i.e., multilevel) statements.

When the interpersonal behavior of an individual at one level of personality is classified, the resulting data might take the form of the following: "The patient complains to the therapist." "He attacks the

[1] Level IV not included.

other group members." These are class statements. They refer to one area of security operations—Level I Communications. A patient says, "I like my therapist and the other group patients." These are also class statements. They refer to another area of behavior—Level II, Conscious Descriptions.

When behavior at one level is compared to behavior at another level, relationship statements are being made. The discrepancies between levels become the focus. We note, for example, that a patient consciously reports himself as friendly, although his behavior as rated by others is hostile. We might say that this patient misperceives his hostile behavior. The word *misperceives* is a relationship term since it compares two levels of observation—the subjective and objective view of the patient's behavior.

When we shift from sentences about a single level to sentences about the differences between levels, a new set of concepts is involved. The term *misperceives* is an example of such a concept. A new vocabulary and syntax come into play. This comes under the heading of the "Logic of Levels." The distinction between class and relationship statements must be kept clear or faulty conceptualization will result.

What Is the Variability Dimension?

We are dealing here with an entirely new and different type of data—the relationships among the levels of personality. We designate this as the variability dimension of personality. This is a most important aspect of behavior. Variability has classically been the stumbling block in the development of personality theory. Every systematic treatment of human nature has had to labor with the perverse inconsistency of behavior. It has never been difficult for theorists to invent typologies and variables of emotions. The trouble has always come when the elusive human subject begins to demonstrate his protean complexity.

The first theoretical lever which succeeded in moving this obstacle was provided by the theory of unconscious motivation. When Sigmund Freud defined the multilevel nature of personality, he offered the first systematic explanation of conflicts, ambivalence, and inconsistency. The essence of a dynamic psychology is variability. The great advantage of a depth theory is that it explains the puzzling complexity and contradiction inherent in human behavior. The psychoanalytic theory of personality and of neurosis is defined in terms of interlevel conflict, i.e., variability. There are certain motives at one level and certain other motives at another. Their interplay spells out the organization of personality. When Freud presents his great tri-

partite division of character into ego, superego, and id, he is mainly concerned with conceptualizing the multilevel variability of behavior.

Variability is involved in almost every aspect of personality that we study. Conflict, ambivalence, defense mechanisms, growth, regression, change, improvement-in-therapy—all these phenomena have the basic factor in common—one unit of measure varies in relation to another. It is a major thesis of this book that all change phenomena are, to a certain extent, functions of a general rigidity-oscillation factor. This factor is measurable and predictable in terms of the time and the amount of variability. Some human beings are more variable, some are less. Some express variation between certain areas of their personality; others express it in different areas. The amount and kind of variability is a most significant variable of human behavior. It defines the type and intensity of conflict. It determines the tendency to change or to maintain a rigid adjustment. It becomes a key variable in the diagnostic and prognostic formulas through which we conceptualize human personality.

Structural, Temporal, and Situational Variability

In considering the variability factor it is useful to make the following distinctions between structural, temporal, and situational variability.

Structural variability refers to differences among the levels of personality. It is well known that drastic discrepancies and inconsistencies develop when we compare the conscious self-description with behavioral or symbolic expressions. The subject who presents himself as a warm-hearted, tender soul may produce dreams or fantasies which are bitterly murderous. Social interactions, as observed by others, may be quite different from the subject's own view of them.

Temporal variability refers to inconsistencies in the same level of behavior over a time span. Time inevitably brings changes, great or small. Many subjects show marked cyclical swings of mood or action. The interpersonal behavior of an individual generally mutates as he moves from age 13 to 31. The temporal changes we study in psychiatric patients are called spontaneous remissions, therapeutic recoveries, psychotic episodes, and the like.

Situational variability refers to differences in cultural and environmental factors. The man who is a lion at home may be a lamb in the office. Reactions often vary according to the sex, age, and cultural status of the "other one" with whom the subject is dealing.

The Kaiser Foundation research project is studying the hypothesis that all of these types of changes are related to the same variability

factor. To distinguish between them may be an artifact, operationally useful in the light of the scientific manageability of change phenomena.

It is difficult enough to measure interpersonal behavior at one time and at one level. To study variation it is necessary to have two sets of data on the same subject which we compare. Three distinct operations are required. We must measure one set of behaviors, then the other, and finally, the discrepancy or change index. We can isolate *temporal* variation by holding constant the level and the situation from which the data come, and measuring the change over time. Repeating the same personality test on a control patient might be an example of this type of variation. Observing in a group therapy session a patient's successive reactions to a nurturant therapist and a competitive fellow patient would illustrate a change in the interpersonal *situation* often leading to variance in the subject's responses. If we establish the kind of variability in one of these classes (e.g., in personality structure) we can make probability predictions as to the kind of variation to be expected in another class.

Comparison Between the Interpersonal and the Variability Dimension

The network of relationships of the various parts of the system—and that is what we deal with here—obviously tells us something about the organization of that system. Interlevel discrepancies are therefore indices of organization. They tell us about the agreement or conflict between the various levels of behavior. They tell us not how the subject relates to his environment, but rather how the different areas of his personality relate to each other. In the interpersonal dimension we study different phenomena and employ different variables. For example, the subject's Level I profile is measured in terms of the sixteen interpersonal variables, summarizing his actual relationships with other people. The Level II profile employs the same sixteen variables to summarize his consciously described relationships with other people. When we compare the Level II and III profiles we get a discrepancy score. We move into a new dimension and must employ a new set of variables.

These variables are not interpersonal, but intrapersonal. *Projection* and *suppression* are terms used to describe certain kinds of relationship between levels of personality data. Notice that they are not directly interpersonal; one does not project or suppress another person. He projects or suppresses his own private motivation. These relationship variables refer not to his social relationships but to the relationships which hold between the areas of his own behavior. Similarly, the rating of amount of interlevel discrepancy must be distinguished

from an interpersonal rating. We do not use the terms *rigidity* and *conflict* to describe what one person does to another—we employ them to describe the tightness, looseness, consistency, or ambivalence among the levels of personality.

Thus, we have introduced into the interpersonal system not just a new variable, but a new category of classification. This is called the variability dimension of personality. A new order of measurement is involved which taps all of the variability phenomena of human behavior: similarity-difference, change, discrepancy, conflict. There are, as we have seen, many types of changes that show up in human behavior—those due to time, situation, and chance, as well as those due to lawful inconsistencies among the levels of personality. The variability dimension is a *formal* aspect of personality as opposed to the more empirical procedures by which we measure interpersonal behavior. Its variables are determined not from empirical observation, but from logical procedures.

In developing the interpersonal variables, we began with actual interpersonal behavior. We collected emotional data of all kinds and then developed a system which best reflected the varieties of interpersonal purpose. In developing the levels of personality the same empirical technique was followed. The different sources of data were examined and combined into the four levels. But in determining the measurement and conceptual units for the variability dimension, a different solution is involved. We are not dealing with actual human behavior, but with indices of change—changes in the scores from the interpersonal dimension. The variables of the variability dimension are not units of the subject's behavior, but of the scientists' behavior, for it is the scientist who performs the operations.[2]

This is a point worth stressing. The number and kind of interpersonal variables were limited and determined only by our observations of what individuals do to each other in their social interaction. The number of levels was similarly determined by empirical evidence. A certain flexibility in the selection of variables and levels does exist because any scientist has the right to increase or diminish the number of categories by which he classifies behavior. In setting up empirical categories, some room for interpretive judgment is allowed—the empirical data guides, but does not dictate. Once the number of levels is determined, however, the system becomes "set." When the scientist

[2] To be more precise we should say that the variability dimension is twice removed from behavior, and the interpersonal dimension is once removed. The patient does something; then the scientist categorizes or measures it. The interpersonal data obtained in this way are once removed from the subject's behavior. Then the scientist goes on to compare the different levels of areas of interpersonal data. These formal, analytic operations are thus twice removed from raw behavior.

goes on to compare the differences between the levels he has selected, there is no longer any freedom for interpretation or creative choice. The logic of levels takes over and dictates the range and nature of the interlevel discrepancies.

An empirical system for measuring multilevel behavior leads, then, to a somewhat new theory of personality organization. A different conception of conflict is defined, not in terms of the interplay between postulated forces, but in terms of the discrepancies between measures.

The Indices of Variability

The relationships between areas of personality are called variability indices. We have already discussed their general similarity to the conception of (but not the clinical use of) Freudian defense mechanisms. These indices comprise one aspect of the variability dimension of personality. They reflect the stability or variation existing among the levels of personality at one point in time. They are to be distinguished from other kinds of change phenomena included in the variability dimension, such as modulations over time (which includes change in psychotherapy) or variability due to differences in the cultural situation. We deal here with indices of interlevel conflicts and concordances.

The term variability index has been assigned to this kind of variation for the following reason. This is a rather neutral term. It is intended to point out that we are not dealing with *mechanisms* or even with behaviors, but rather with formal, comparative operations. These discrepancy relationships do not "do anything." It is risky to mechanize or humanize them. There are no body organs or neural centers for repression or suppression.

From the empirical point of view, there is simply behavior at different, discriminable levels of expression. There are measured relationships between these levels. In the present insecure state of our knowledge it seems safest to call them indices. But indices of what? To answer this question is to produce a theory of personality organization.

Variability index is, we expect, a temporary holding term which can be replaced by a more dynamic term whenever the nature of the dynamic principle is determined. In the meantime, it seems to express exactly what we know to be true about the interlevel relationships. It tells us how stable or variant these relationships are. If the themes of Level II parallel those of Level III, then the variability index is low. The aggression, let us say, of one level is repeated at the other. If the two levels are discrepant—if, for example, the aggression at Level II changes to docile cooperativeness at Level III—a high variability index

is obtained. Variation between the levels is present. There is another and more important aspect of variability. There is evidence (see Appendix 3) that the more stable the organization of personality—that is, the more the data from Levels II, III, and I tend to repeat the same themes—the less variation we can expect in the personality organization over time. Conversely, the more conflict or oscillation among the levels of personality, the more change we can predict will take place in the future; and this includes change in therapy. These findings make the term variability index doubly appropriate. While we cannot, at this point, say that interlevel discrepancies possess the dynamic qualities of pushing toward equilibrium, we can say that they refer to structural stability of personality (this by definition), and they predict the degree of stability of personality organization to be expected in the future. They give us, first of all, an index of systematic variation in the personality structure at the time of evaluation, and they point out the direction and amount of change to be expected over future time.

The Function of Variability Indices

The interpersonal system does not assign a function to these interlevel discrepancies. Behavior at all levels is seen as having one basic function to ward off survival anxiety. The discrepancies or *conflicts* between levels are seen as another dimension of conception which concerns the psychologist's behavior. It is the psychologist who measures the discrepancy or conflict between the two levels of the patient's behavior. We assign, for semantic convenience and heuristic necessity, conceptual titles to the important discrepancies between the levels of the subject's behavior. We do not, however, assign functions to them. The only assumption upon which an empirical theory of personality need be based is the premise of survival anxiety. The only function we assign to behavior is the maintenance of security and the diminishing of anxiety. The indices of difference, ambivalence, or conflict among the varieties of behavior do not seem to require the postulation of additional functions.

Closely connected to this question of the function of defense mechanisms (or variability indices) is another issue which has received considerable attention in the recent literature. This involves the differentiation between *adaptive* and *defensive* functions. Are defense mechanisms pathological and neurotic, or can they sometimes be constructive? Fenichel, for example, places all "successful defenses" under the heading of sublimation, and describes "unsuccessful defenses which necessitate a repetition or perpetuation of the warding-off process to prevent the eruption of the warded-off impulses." Mowrer has dis-

tinguished between the mechanisms used in development and those used in defense. This issue of the adaptability or pathology attached to the discrepancies of concordance and conflict in personality is invariably complicated by value judgments (e.g., what is adaptive?) and theoretical assumptions about the function of defense mechanisms. These are legitimate questions from the standpoint of the psychoanalytic approach and deserve the attention they have received.

From the position of the interpersonal system, this issue could be interpreted as follows: (1) the variability indices have no function; (2) discrepancy or conflict between levels cannot be assigned an adaptive or maladjustive value by definition but must be interpreted as part of the total personality picture. The level and amount of the conflict and its relationship to the over-all character structure determine the positive or negative interpretation.

A not infrequent clinical misinterpretation of psychoanalytic theory implies that defense mechanisms are negative or neurotic processes. This is, indeed, one reason which supports the use of the more neutral term variability index for the interlevel conflicts. A discrepancy between conscious self-description and "preconscious" fantasy (which we shall designate repression) should not necessarily be considered unhealthy. If the Level II self-image is one-sided and the "preconscious" fantasy a moderate balance in the opposite direction, the conflict might well designate an adaptive equilibrium. If the patient is markedly disidentified with his father, the adjustive aspect of this discrepancy would certainly depend somewhat on the kind of motives attributed to self, to father, and to others.

In the subsequent pages we shall be considering several variability indices which have been given names of psychoanalytic defense mechanisms where these seemed to fit the nature of the conflict. In order to understand the meaning and use of these indices in the interpersonal system, it is essential that two points be kept in mind: (1) These concepts are not mechanisms or dynamisms, but rather numerical indices of interlevel variation; as such they have no function. (2) They have no a priori value-loading as far as adjustment and maladjustment are concerned; they can describe flexibility and healthy ambivalence, or they can indicate pathological rigidity or maladaptive oscillation.

Two Interpretations of Variability

When we obtain the variability indices among the levels of personality, two interpretations of the resulting variation can be made—both of theoretical and practical interest. We can concentrate on *what* the variation is, or we can focus on *how much*. The first tells us that the individual *represses* so much hostility or *misperceives* this

much passivity. The second way of handling variability indices is to disregard the content of the interpersonal themes, study the pattern of variability for all the discrepancy relationships, and simply determine how variable this person is in over-all terms. This focuses on the amount of variability. We can then make such statements as, "This patient is extremely conflicted and variable, being two sigmas above the mean."

We have seen that the logic of levels determines the kind of relationships among levels. We have developed a system in which there are eight general levels and areas of personality. Therefore, when we ask the question, "What are the relationships among the areas of personality?" the answer is already settled for us. They are the relationships among these eight areas—the discrepancies which occur when we compare each level or sublevel with every other level. Formally, then, there are as many relationships or variability indices as there are permutations among the areas.

Figure 31 presents these eight areas. Each circle represents a discrete area of personality data. The lines joining the circles represent the interlevel or interarea discrepancy indices determined by the logic of levels. They comprise the network of variability indices which link the parts of personality structure into an organized totality. Validation of these indices is beyond the scope of this book. Thirteen of these relationships—those most relevant to current theory and clinical practice—are defined in this chapter.

The Record Booklet for Interpersonal Diagnosis of Personality (Appendix 4, Figure 61) provides a simplified method for measuring discrepancy indices and for plotting them in diagrammatic summary form.

The next task is to determine the meaning of these interlevel relationships. The subtractive procedures, it will be recalled, indicate the kind and amount of interpersonal behavior in one area that is present in another area. Giving names to these relationships is, in one way, the simplest problem of all. The term which best mirrors the relationship is selected and operationally defined in terms of the cross-level subtraction. A procedure of this sort satisfies all the logical requirements, but the reader is likely to remain unsatisfied and to ask the further questions, "This is all very well, but what do they mean? What is their functional value? What do they predict?"

A scientific system can be objective and logically virtuous and still have no function except perhaps to entertain the originator. It would be possible to assign very impressive terms to the interlevel relationships, calling this one "repression" and that one "displacement" and a third "introjection," etc., until the long list of relationships (or the

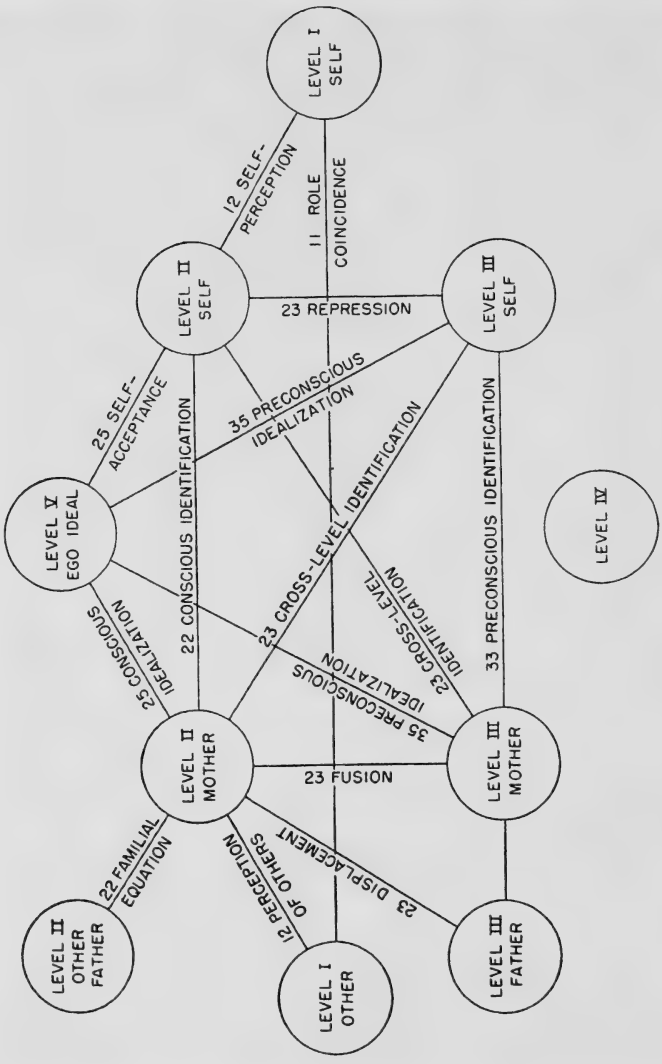


FIGURE 31. Schematic Diagram Illustrating the Operational Definition of Generic Variability Indices. N B. There are two types of cross-level identification.

imagination) is exhausted. The resulting nomenclature would be logically consistent and objective (since all the terms would be operationally defined), but, what is rather unfortunate, it would be quite irrelevant. In developing a system of personality, the first problem is the selection of the categories. The next is to validate them, that is, to relate them to other independent and relevant variables, to harness them to functionally useful predictions. The three criteria for effective research, we recall, are objective measurement, logical analysis, and, far from the least important, functional relevance.

If it were feasible to list and label all the possible interlevel relationships, the next task would be to validate them against functional criteria. Such labeling and validating would place an enormous drain on inventive imagination, research resources, and reader endurance alike. At this point, we shall attempt to define twelve generic variability indices, and then list forty-eight specific indices which fall into the twelve broader categories.

The twelve variability indices about to be defined have been chosen because they appear to possess the most clinical meaning, functional value, and theoretical implication. As we begin this exercise in the mathematics of personality, it is well to keep in mind the formal or logical aspect of the task. In one sense, it is not absolutely necessary to develop a notational system for linking up the levels of personality. In our diagnostic procedures we could conceivably just present the interpersonal behavior at all levels. We would indicate that the subject is hostile at Level I, claims to be docile at Level II, describes his father as autocratic at Level II Other, etc. The language of variability allows us to relate these areas or levels of personality. It allows us to define systematically the dynamic network which links up the described areas. This is a great convenience. Like any formal, notational device, the language of variability makes possible concise, precise summaries of conflict, concordance, discrepancy, etc.

Operational Definition of the Variability Indices

There are twelve generic variability indices to be defined and validated in this chapter. Most of these generic discrepancies have several subdivisions which are specific indices referring to the important familial figures to which the subject is related. Thus, under the generic index *conscious identification* there are four specific indices referring to identifications with father, mother, spouse, and therapist. Table 10 presents the twelve generic variability indices and indicates the subvarieties which are subsumed under this general title.

In the left column of Table 10 are listed the most familiar titles of the twelve generic variability indices. In the right-hand column are

TABLE 10

INFORMAL LISTING OF THE TWELVE GENERIC VARIABILITY INDICES

Title of Variability Indices	*Code Number of the Specific Variability Indices Subsumed Under this General Title*
Role Coincidence	11 SO
Interpersonal Perception	12 SS, 12 OO
Conscious Identification	22 SM, 22 SF, 22 SSp, 22 ST
Equation	22 MF, 22 MSp, 22 FSp, 22 MT, 22 FT, 22 SpT
Repression	23 SH
Cross-level Identification	23 MH, 23 FH, 23 SpH, 23 TH, 23 SO, 23 SM, 23 SF, 23 SSp
Conscious-"Preconscious" Fusion	23 MM, 23 FF, 23 SpSp
Displacement	23 MF, 23 FM, 23SpM, 23 SpF 23 M Sp, 23 F Sp, 23 TM, 23 TF, 23 TSp
"Preconscious" Identification	33 HM, 33 HF, 33 HSp, 33 HO
Self-Acceptance	25 IS
Conscious Idealization	25 IM, 25 IF, 25 ISp, 25 IT
"Preconscious" Idealization	35 IH, 35 IM, 35 IF, 35ISp, 35 IO

noted the code designations of the specific variability indices which are the subvarieties of the generic indices. It will be observed that there are forty-eight of these specific indices. All of these will be operationally defined in the subsequent pages.

It will be noted that many of these generic variability indices have been given the names of classical psychoanalytic defense mechanisms. Although borrowing terminology from another theory has its risks, we have ventured to employ the familiar terms wherever they seem to fit the general nature of the discrepancy concerned. In this manner we have sought to avoid the proliferation of novel terms and the idiosyncratic "timid neologisms" which Egon Brunswick has deplored. Several of the discrepancy indices, however, involve reflex interpersonal communications—a level of personality which has not been isolated by the psychoanalytic theory. This has necessitated the introduction of some new terminology—or in Freudian language, some new "defense mechanisms."

Confusion between these variability indices and psychoanalytic mechanisms of the same name may be avoided if the reader keeps in mind the operational definition of each index. It may be helpful to present a diagrammatic operational definition of these twelve variability indices. They are defined by the amount of discrepancy between levels or areas of personality as illustrated in Figure 31.

Several points require comment. First, it will be noted that the relationships of Level IV (the level of the unexpressed unconscious) to the other levels are not included. No data are available for this area of personality. It must also be noted that only one circle is presented for

each area of "other" behavior.[3] In practice, there are several "others" who are always included in the personality diagram. As we recall from the chapter on Level II (Chapter 8), the conscious view of mother, father, and spouse (and, where possible, the therapist) is routinely included in the personality pattern. Similarly, in scoring fantasy material, we separate the themes attributed to father, mother, and cross-sex figures. These specialized circles are not all included in Figure 31. We have included an extra Level II Other circle, labeled "father," to illustrate the variability indices of *Familial equation*, defined as the process of consciously ascribing similarities or differences to various family members or describing nonmembers (such as the therapist) as being like or unlike family members. If a patient describes his therapist in the same way that he describes his father, the two indices will show little or no discrepancy. We would be able to say, "The patient consciously equates his therapist with his father." We have also included an extra Level III Other circle to illustrate the variability indices of *displacement*, which is defined as the process of consciously ascribing to one "other" (e.g., father) the interpersonal traits which are preconsciously assigned to another "other" (e.g., mother).

Operational Definition of Forty-eight Specific Variability Indices

It was mentioned above that the twelve generic variability indices subdivide into forty-eight specific variability indices. If we consider all the permutations and combinations of interrelatedness among the levels and the personages at each level, a list of variability indices several times forty-eight would be obtained. The forty-eight indices now to be defined were selected on the basis of the theoretical and clinical meaningfulness. The plan of exposition is as follows: We shall first present an operational definition for each of the forty-eight variability indices and a formal title for the high and a low discrepancy for each.

The listing, coding, formal designation, and operational definition of each variability index is contained in Table 11. The key to the numbers and letters employed in coding the variability indices is presented in Table 12.

The Coding of the Variability Indices

The first column in Table 11 gives the code number of the variability index. The code number is a simple, straightforward notational device which summarizes exactly what discrepancy is involved in this index. Every code number for a variability index comprises four

[3] An exception to this statement—two circles are included in Figure 31 for Level II Other and Level III Other to illustrate the indices of equation and displacement.

TABLE 11

OPERATIONAL DEFINITION OF FORTY-EIGHT INDICES OF VARIATION

Code	*Low Discrepancy Between the Two Measures Is Called:*	*High Discrepancy Between the Two Measures Is Called:*	*This Variability Index Is Operationally Defined by the Discrepancy Between:*
11 SO	Role coincidence	Role reciprocity	Level I self vs. Level I other (specialized or total)
12 SS	Self-perception	Self-deception	Level I self vs. Level II self
12 OO	Other-perception	Other misperception	Level I other vs. Level II other
22 SM	Conscious identification (maternal)	Conscious disidentification (maternal)	Level II self vs. Level II mother
22 SF	Conscious identification (paternal)	Conscious disidentification (paternal)	Level II self vs. Level II father
22 SSp	Conscious identification (spouse)	Conscious disidentification (spouse)	Level II self vs. Level II spouse
22 ST	Conscious identification with therapist	Conscious disidentification with therapist	Level II self vs. Level II therapist
22 MT	Maternal-therapist equation	Maternal-therapist disequation	Level II mother vs. Level II therapist
22 FT	Paternal-therapist equation	Paternal-therapist disequation	Level II father vs. Level II therapist
22 SpT	Spouse-therapist equation	Spouse-therapist disequation	Level II spouse vs. Level II therapist
22 MF	Maternal-paternal equation	Maternal-paternal disequation	Level II mother vs. Level II father
22 MSp	Maternal-spouse equation	Maternal-spouse disequation	Level II mother vs. Level II spouse
22 FSp	Paternal-spouse equation	Paternal-spouse disequation	Level II father vs. Level II spouse
23 SH	"Preconscious" duplication	"Preconscious" repression	Level II self vs. Level III hero
23 MH	Cross-level identification (maternal)	Cross-level disidentification (maternal)	Level II mother vs. Level III hero
23 FH	Cross-level identification (paternal)	Cross-level disidentification (paternal)	Level II father vs. Level III hero
23 SpH	Cross-level identification (spouse)	Cross-level disidentification (spouse)	Level II spouse vs. Level III hero
23 TH	Cross-level identification (therapist)	Cross-level disidentification (therapist)	Level II therapist vs. Level III hero
23 SO	Cross-level identification (other)	Cross-level disidentification (other)	Level II self vs. Level III other
23 SM	Cross-level identification (maternal)	Cross-level disidentification (maternal)	Level II self vs. Level III maternal images
23 SF	Cross-level identification (paternal)	Cross-level disidentification (paternal)	Level II self vs. Level III paternal image
23 SSp	Cross-level identification (cross-sex)	Cross-level disidentification (cross-sex)	Level II self vs. Level III cross-sex images
23 MM	Fusion (maternal)	Diffusion (maternal)	Level II mother vs. Level III maternal image

TABLE 11—Continued

OPERATIONAL DEFINITION OF FORTY-EIGHT INDICES OF VARIATION

Code	*Low Discrepancy Between the Two Measures Is Called:*	*High Discrepancy Between the Two Measures Is Called:*	*This Variability Index Is Operationally Defined by the Discrepancy Between:*
23 FF	Fusion (paternal)	Diffusion (paternal)	Level II father vs. Level III paternal image
23 SpSp	Fusion (cross-sex)	Diffusion (cross-sex)	Level II spouse vs. Level III cross-sex image
23 MF	Displacement	Cross-level diffusion	Level II mother vs. Level III paternal image
23 FM	Displacement	Cross-level diffusion	Level II father vs. Level III maternal image
23 SpM	Displacement	Cross-level diffusion	Level II spouse vs. Level III maternal image
23 SpF	Displacement	Cross-level diffusion	Level II spouse vs. Level III paternal image
23 MSp	Displacement	Cross-level diffusion	Level II mother vs. Level III cross-sex image
23 FSp	Displacement	Cross-level diffusion	Level II father vs. Level III cross-sex image
23TM	Displacement	Cross-level diffusion	Level II therapist vs. Level III maternal image
23 TF	Displacement	Cross-level diffusion	Level II therapist vs. Level III paternal image
23 TSp	Displacement	Cross-level diffusion	Level II therapist vs. Level III cross-sex image
33 HM	"Preconscious" identification (maternal)	"Preconscious" disidentification (maternal)	Level III hero vs. Level III maternal image
33 HF	"Preconscious" identification (paternal)	"Preconscious" disidentification (paternal)	Level III hero vs. Level III paternal image
33 HSp	"Preconscious" identification (cross-sex)	"Preconscious" disidentification (cross-sex)	Level III hero vs. Level III cross-sex image
33 HO	"Preconscious" identification (total)	"Preconscious" disidentification (total)	Level III hero vs. Level III total other
25 IS	Self-acceptance	Self-rejection	Level V ideal vs. Level II self
25 IM	Maternal idealization	Maternal devaluation	Level V ideal vs. Level II mother
25 IF	Paternal idealization	Paternal devaluation	Level V ideal vs. Level II father
25 ISp	Spouse idealization	Spouse devaluation	Level V ideal vs. Level II spouse
25 IT	Therapist idealization	Therapist devaluation	Level V ideal vs. Level II therapist

TABLE 11—Continued

OPERATIONAL DEFINITION OF FORTY-EIGHT INDICES OF VARIATION

Code	*Low Discrepancy Between the Two Measures Is Called:*	*High Discrepancy Between the Two Measures Is Called:*	*This Variability Index Is Operationally Defined by the Discrepancy Between:*
35 IH	"Preconscious" hero idealization	"Preconscious" hero devaluation	Level V ideal vs. III hero
35 IM	"Preconscious" maternal idealization	"Preconscious" maternal devaluation	Level V ideal vs. Level III maternal images
35 IF	"Preconscious" paternal idealization	"Preconscious" paternal devaluation	Level V ideal vs. Level III paternal images
35 ISp	"Preconscious" cross-sex idealization	"Preconscious" cross-sex devaluation	Level V ideal vs. Level III cross-sex images
35 IO	"Preconscious" other idealization	"Preconscious" other devaluation	Level V ideal vs. Level III other

TABLE 12

KEY TO NUMBERS AND LETTERS EMPLOYED IN CODING VARIABILITY INDICES

Number Codes	*Letter Codes*
1 = Level I	S = Self (i.e. the subject)
2 = Level II	M = Mother (the subject's own mother is at Level II and the maternal image at Level III)
3 = Level III	F = Father or paternal image
5 = Level V	Sp = Spouse (if at Level II) or cross-sex figures (in Level III fantasies)
	T = Therapist
	I = Ego ideal from Level V

elements: two arabic numbers and two letters. The numbers indicate which levels are being compared. Thus, "12" means that behavior at Level I is being compared with behavior at Level II; "22" indicates that the comparison is between two different scores at Level II. The two letters refer to the respective personages at each level that are being compared. Thus, "12 SS" indicates that the subject's own behavior seen by others (Level I) and that seen by self (Level II) are being compared. The coding "23 FM" indicates that the subject's conscious description (Level II) of his father is being compared with the summed maternal images for Level III.

It will be noted that any code number is actually a formula summary of the processes involved in obtaining the index and is thus an abbreviated operational definition of the index. Since dozens of variability indices are obtained for each patient studied in the Kaiser Foundation project, the codings allow a numerical filing system for variability data.

The Titles of Variability Indices

For each variability index, there are two titles which refer to high or low discrepancies between the two levels or personages involved. If a patient's self-description is close to his observed behavior (i.e., a low discrepancy) the first, or positive, designation "self-perception" is employed. If the two levels are far apart (i.e., a high discrepancy) then the second, or negative, designation "self-deception" is used.

The specific procedure for measuring the variability indices will be presented below. It will suffice here to say that if a discrepancy between two levels is below the mean of the normative sample, the positive term (second column in Table 11) is assigned. If the discrepancy is above the mean, the negative term (third column) is employed.

The Operational Definitions of Variability Indices

The fourth column in Table 11 contains the operational definition of each of the forty-eight variability indices. This involves simply the specific designation of the levels and personages being compared.

Methodology for Measuring Variability Indices

The Kaiser Foundation psychology research project has devoted several years to the development of methods for measuring the kind and amount of variability between levels of personality and the kind and amount of variability between two tests of the same level administered at different times. The former are *structural variability indices*; the latter are called *temporal variability indices*.

A main criterion for an effective discrepancy measure is the reflection of changes in line with the general meaning of the interpersonal circle. Thus a large numerical discrepancy between two levels or between the same level tapped in pretherapy and posttherapy tests should designate an extreme change in interpersonal behavior, e.g., from submission to dominance.

One method of assessing discrepancy involved measuring the linear distance between the two scores in centimeters. This has the advantage of directness and simplicity. It had the overweighing disadvantage of doing violence to the concept of the circle. A large centimeter difference was deceptive where the pre- and posttherapy scores were far from the center of the circle. Both scores could be in the same octant and involve a similar extreme interpersonal behavior (e.g., sadism) for which the centimeter distance index would be very large.

The development of the numerical diagnostic codes (see Chapter 12) made possible improved methods of measuring change.[4] In the nu-

[4] The remainder of this chapter was written by Joan S. LaForge.

merical code system every score falling in the same octant is assigned the same code category. Thus a simple subtraction process yields a discrepancy estimate. If the patient is a 5 before therapy and a 2 after therapy, he has changed three units (i.e., $5 - 2 = 3$). At first a crude, intuitive discrepancy system was established. Arbitrary values were assigned to the various differences. The comparison between the extreme and the moderate scores (e.g., 74) became an insoluble problem because there was no provision for assigning discriminatory weights.

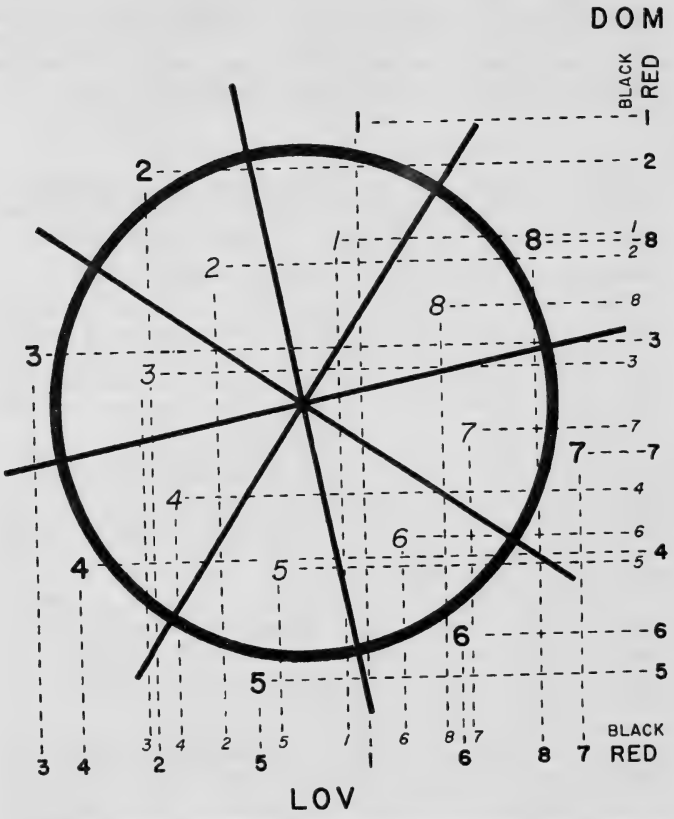


FIGURE 32. Model Employed To Determine Summary Points on the Diagnostic Grid and To Calculate Horizontal and Vertical Discrepancy Values.

The attempt was then made to establish a set of points on the circle to represent the eight octants at two intensity levels, a total of sixteen points. Any point falling in an octant is then considered to fall always at one point. A model establishing these points was derived in the following way. The plane was divided into two areas (inside and outside areas), one standard deviation from the center point being the dividing line. Those points in the inside area were considered to be of moderate intensity. The center of mass of each pie-shaped area was taken as the location of the representative point and derived from the formula

$$\frac{\iint_R x\, ds}{\iint_R ds} \quad \text{and} \quad \frac{\iint_R y\, ds}{\iint_R ds}$$

where x and y are points along the abscissa and ordinate, and s is the area, integrated over the region R. Once this collection of eight points was established, the problem of finding a point-representation for the extreme intensity of each octant was a little more difficult. There can be no center of mass because each outer area is infinite.

At this juncture, consideration of the meaning of relative discrepancies was taken into account. Clearly a change in the same octant should be less than the change, even at the least intensity, between two octants. With this principle in mind, a set of points was arbitrarily selected to represent the extreme intensities for the eight octants, maintaining, for example, that a red 1–black *1* discrepancy be a little less than a black *1*–black *2* discrepancy.

The intersection of each point with the x (hostility-affiliation) and y (dominance-submission) axes was established, and the continuum of these points was assigned the values from $+56$ to -56, with zero at the center of the circle (Table 11). Now it was possible to establish vertical and horizontal components of each discrepancy. The geometric distance given by the formula

$$\sqrt{d_x^2 + d_y^2}$$

(where d_x is the vertical discrepancy and d_y the horizontal) is then taken as the measure of discrepancy.

Here another conception of the meaning of discrepancies was considered. At all times the discrepancy between any two equally distant points should be the same, regardless of the position of the points on the circle, i.e., red 1–black *1* should equal red 2–black *2*. However, from Table 13, the following is noted: for red 1–black *1* the x and y discrepancy components are -23 and -5, and for red 2–black *2* they are -19 and $+13$. The squares of each respective discrepancy are 554 and 530.

TABLE 13

HORIZONTAL (LOV) AND VERTICAL (DOM) VALUES FOR EACH OCTANT

		Dom	*Lov*			*Dom*	*Lov*
Red	1	+56	+11	*Black*	*1*	+33	+ 6
	2	+47	−32		*2*	+28	−19
	3	+11	−56		*3*	+ 6	−33
	4	−32	−47		*4*	−19	−28
	5	−56	−11		*5*	−33	− 6
	6	−47	+32		*6*	−28	+19
	7	−11	+56		7	− 6	+33
	8	+32	+47		*8*	+19	+28

Theoretically, the square roots of these numbers should be equal if our principle is to be met. The two square roots are 23.537 and 23.022. In all such cases encountered, the *closest whole number* to both square roots was taken to be the discrepancy (in this case, 23). In this way fourteen possible discrepancies are obtained. They are presented in Table 14.

TABLE 14

ALL POSSIBLE DISCREPANCIES AROUND THE PAIR 1–*1* AND THEIR MAGNITUDES

Pair	*Discrepancy*
1 1 (*1 1*)	00
1 *1* (*1* 1)	23
1 2	26
1 *2* (*1* 2)	41
1 2	44
1 3	48
1 4	62
1 *3* (*1* 3)	66
1 5	68
1 3	81
1 *4* (*1* 4)	84
1 *5* (*1* 5)	91
1 4	105
1 5	114

Key: The italic numbers refer to moderate (black) diagnostic intensities and the roman-face numerals to extreme (red) intensities

The model was then examined in terms of meaning for these discrepancies and the conceptual-numerical relationships. Table 14 shows one set of discrepancies and their relative magnitudes.

Careful examination of this table shows the inner relationships of all possible distances from one octant. All other octants show the same relationships because of the equivalent-distant principle used in establishing discrepancy magnitudes. Considering the extreme combinations only, we have the following set of discrepancies: 1 1 = 00,

1 2 = 44, 1 3 = 81, 1 4 = 105, 1 5 = 114. The same grouping for lesser intensity combinations yields the following: *1 1* = 00, *1 2* = 26, *1 3* = 48, *1 4* = 62, *1 5* = 68. Pairwise comparison of equal octant but different intensity groups shows that as the distance around the circle becomes greater the ratio of the two discrepancies becomes less, i.e., 00:00, 26:44, 48:81, 62:105, 68:114. This relationship leads to the fact that the discrepancy between *1 5* (most extreme of the lesser intensities) is between the discrepancy for 13 and 12, placing a greater discrepancy value for a moderately distant discrepancy of extreme intensity, i.e., 13, than on an extremely distant discrepancy of moderate intensity, i.e., *1 5*.

Placing all discrepancies in intervals of 20, we have the results in Table 15.

TABLE 15

ILLUSTRATION OF THE GROUPING OF ALL POSSIBLE DISCREPANCIES INVOLVING THE DIAGNOSTIC CODES 1 AND *1*

Code Discrepancy	*Numerical Value*
1 1 (*1 1*)	00–20
1 *1* (*1* 1), 1 2	21–40
1 2 (*1* 2) 1 2, *1 3*	41–60
1 4, 1 *3* (*1* 3), *1 5*	61–80
1 3, 1 *4* (*1* 4), 1 *5* (*1* 5)	81–100
1 4, 1 5	101–120

This grouping shows approximate equations of the various mixed discrepancies, such as *1 4* approximately equals 1 *3* approximately equals *1 5*, i.e., the two most extreme moderate-intensity discrepancies are approximately equal to the discrepancy between moderate and intense of medium distance around the circle.

A table of weighted scores for each possible interlevel discrepancy is presented in Appendix 5.

This consideration of discrepancy relationships seems to indicate that the model we constructed is consistent with the meaning of change in terms of the theory of the interpersonal circle.

IV

Interpersonal Diagnosis of Personality

14

Theory of Multilevel Diagnosis

The preceding thirteen chapters have presented a theory and an empirical system of personality. A complicated array of variables have been described, and the relationships among variables have been classified.

In this fourth section of the book we are going to apply this system of personality to the task of clinical diagnosis and prognosis. The numerical code diagnosis, it will be recalled, provides 65,536 personality types—at four layers of personality. It is clearly impossible to expect to locate sample cases illustrating each of these 65,536 multilevel combinations. It is equally out of the question to give a clinical description of each of these types.

To use this diagnostic system in clinical situations it is necessary only to employ the notion of multilevel analysis and to apply a common-sense interpretation of the numerical diagnostic formula. The eight-digit diagnostic code, it will be recalled, is nothing more than a shorthand summary of the way in which the patient responded at the several levels of personality.

The system is quite complex in the sense that it provides for a great variety of types. But the processing of the data and the derivation of the diagnostic code is a straightforward clerical, technical (nonprofessional) task. The interpretation of the diagnostic code is not a demanding assignment since the diagnosis for every level simply denotes which interpersonal behaviors the patient manifested. The clinical implications follow quite naturally. We simply ask the questions: What does it mean if he says this about himself but acts that way? What does it mean if he says this and manifests these underlying behaviors?

Application of the system is facilitated by some clinical experience with it, and by some knowledge of the empirical results obtained in normative studies. These will be presented in the eight clinical chapters to follow.

There is, however, no high-powered theory which has to be mastered. There is the one assumption that all interpersonal behavior serves to reduce anxiety and to maintain self-esteem. The rest is based on behavior. What did the patient do, say, indirectly express? A multilevel summary of interpersonal behavior yields considerable additional information about the rigidity of security operations (kind and degree) or about conflicts and ambivalences (kind and degree).

This information is then used to answer functional questions about motivation and treatment.

The system can be seen as a hierarchical pattern of levels which unfold symmetrically. For research or clinical categorization it is convenient to work from the surface into the indirect or deeper areas of personality.

Single-Level Diagnosis

In considering an individual case or a general research problem we look first at Level I. There are sixteen interpersonal types (eight moderate and eight intense) at this overt behavioral level. Much of our research has taken place at this single level. We have attempted to discover what probability indices hold for this level. We discover, for example, that patients who are hypernormal (code 8) at Level I remain in psychotherapy only half as long as distrustful (code 4) patients; and that ulcer patients do not differ significantly from hypertensive patients at this level.

Double-Level Diagnosis

Adding the Level II material we get a much more complicated two-layer pattern. First, it should be noted that there are probability findings which allow us to predict on the basis of Level II alone. When we combine the Level I and II indices, new meaning appears. The number of possible types multiplies. There are 256 two-level types (16 at Level I $\times$ 16 at Level II).

A double-level diagnosis is useful because it points up conflict or discrepancy in the presenting façade. Some patients give a dependent, fearful symptomatic picture (Level I = 6) and may see themselves as independent and self-confident (Level II = 2). The code label "62" thus becomes loaded with meaning. It points to an ambivalent motivation, to a marked misperception by the patient of the effect of his symptom. It complicates the clinical predictions we are to make about the patient since his symptoms (6) are dependent, and his self-regard is the opposite (2).

The double-level diagnosis "66" forecasts an entirely different clinical course. Here, the docile, fearful overt symptomology is duplicated

by the conscious self-perception. A two-layer commitment to the same interpersonal operations is indicated.

Triple-Level Diagnosis

The summary code of the subject's fantasy-hero behavior provides the third digit for the diagnostic formula. There are sixteen fantasy-hero codes (eight moderate and eight extreme). When these are combined with the double-level codes, a total of 4,096 diagnostic types exists (256 double-level types $\times$ 16).

When we consider the third digit in any diagnostic formula, considerable empirical information is available. We know, for example, that the fantasy-hero score predicts future behavior. Thus, the third digit is of clinical interest in itself. It indicates what shifts in conscious self-perception we can anticipate. When combined with the first digits it fills out a more meaningful pattern.

A "773," for example, denotes a patient who is friendly and overconventional at the levels of overt presentation and conscious self-description. The third digit, "3," indicates a "preconscious" concern with hostility. It suggests that underlying antisocial feelings exist beneath a façade of bland normality and that they will probably appear in future behavior at the overt levels.

The clinical meaning of a "773" is very different from a "777." The latter maintains a solid, triple-layer structure of affiliative, overconventionality. Self-satisfaction would probably be high and motivation for therapy low, since the patient cannot tolerate hostile or unconventional feelings at any of the top three layers. A "773" would be handled quite differently, clinically, since a conflict exists between a conventional façade and underlying "preconscious" sadistic feelings.

Four-Level Diagnosis

The fourth digit in the diagnostic code denotes the themes attributed to fantasy "others." There is less empirical significance or clinical meaning attached to this layer. This level has not been studied extensively, and no specific empirical significance attaches to it. This layer does suggest how rigid or flexible the subject's range of security operations is. If themes which are avoided at the top three layers were to appear in the fourth code digit, then we might assume that the subject does not completely avoid that area. Consider, for example, two patients who present triple-layer structures of solid distrust and bitterness (444). One might have a fourth digit of "4," which would indicate a complete commitment to schizoid operations. The second patient might present an "8" in his "preconscious-other." The code "4448" indicates that some tender, responsible feelings exist and can

be tolerated, at least at this more indirect level of expression. A common-sense hypothesis might be that the latter patient would have a slightly less pessimistic prognosis than the patient who could not allow any affiliative behavior at any level.

The fourth digit is, therefore, included in the diagnostic code but is given minimal consideration in the clinical sections to follow.

When the 16 "preconscious-other" codes are combined with the 4,096 triple-layer types, a total of 65,536 is obtained.

Organization of the Interpersonal Typology

A system of interpersonal diagnosis which involves this many types may appear bewildering in its scope. We have stressed, however, that the system is fairly simple to apply if the common-sense meaning of any particular multilevel combination is kept in mind. First the eight-digit formula is derived for a patient. To understand the patient's personality organization we simply translate the code digits into diagnostic terms. The conflicts or rigid duplications existing in the multilevel pattern will become apparent.

The eight diagnostic chapters which follow present the clinical and research data now available. These chapters refer to the eight typological categories at Levels I and II. The "schizoid" chapter is concerned with patients who present as "44's" at Levels I and II. In each clinical chapter the general findings typical of the pure, unconflicted case will be presented.

15

Adjustment Through Rebellion: The Distrustful Personality[1]

This chapter deals with those individuals who select distrust and rebellion as their solutions to life's problems. This is the "44" personality type. In their crucial relationships with others, these human beings consistently maintain attitudes of resentment and deprivation. They handle anxiety by establishing distance between themselves and others. At the critical moments of relationship with others they become cynical, passively resistant, and bitter.

The distrustful way of life is in some ways a puzzling phenomenon. The ideals of our culture stress adjustment, closeness, and cooperation. It is generally taken for granted that trustful, loving relations with certain important others is one of the basic human goals. There exists, however, a very large group of individuals who consistently avoid this relationship. They compulsively eschew closeness with others. They are traumatized and threatened by positive feelings.

These human beings often do not voluntarily seek distance and disappointment from others. In their conscious ideals, on the contrary, they may strive and long for tenderness. They are usually frustrated, depressed, and most dissatisfied with their situations.

They regularly manifest, however, the reflexes of distrust and resentment. They involuntarily provoke rejection and punishment from others. They cannot tolerate durable relationships of conformity or collaboration.

The Purpose of Distrustful Behavior

Those human beings who are overtly bitter and cynical have selected these operations because they find them most effective in ward-

[1] In this chapter and the subsequent seven, we shall be discussing pure interpersonal types based on Level I-M and II-C diagnosis. We shall describe the unconflicted subject who presents the same security operations in his symptomatic behavior and in his conscious self-descriptions. Space does not permit a consideration of the conflicted types.

ing off anxiety. Pain and discomfort are traditionally associated with alienation from others, but for these subjects this discomfort is less than the anxiety involved in trustful, tender feelings. For the person who has experienced past rejections or humiliations there are certain comforts and rewards in developing a rebellious protection. The essence of this security operation is a malevolent rejection of conventionality. Trust in others, cooperation, agreeability, and affiliation seem to involve a certain loss of individuality. Giving or sharing or trusting requires a sacrifice of pure narcissism and some relinquishing of the critical function.

The rebellious adjustment provides a feeling of difference and uniqueness which is most rewarding to some individuals. Inevitable ties and responsibilities go with an agreeable, conventional adjustment. For the person who avoids this way of life there are certain rewards —a rebellious freedom, a retaliatory pleasure in rejecting the conventional, a delight in challenging the taboos, commitments, and expectations which are generally connected with a durable affiliative relationship.

In the extreme case, the security operations of distrustful alienation involve a spiteful and bitter rejection of love and closeness. This phenomenon has been best understood by Sullivan. He has given a most thoughtful description of this process:

> Some years ago, the young nephew of one of my friends was admitted to the Henry Phipps Psychiatric Clinic. The patient was suffering an acute schizophrenic disturbance, catatonic in type. He was placed under principal care of a close friend of mine, and I followed developments closely and saw the patient occasionally. As he became unmanageable, he was transferred to the Sheppard and Enoch Pratt Hospital, arriving there mute and requiring feeding by the nasal tube. He was extremely resistive to this feeding *unless* I did it, in which latter case he came to help with the insertion of the tube. I thoughtlessly took over on all these occasions and otherwise greatly interested myself in him. As he was convalescing quite nicely, he underwent what I call a malevolent transformation of interpersonal relations and became first mischievous and later definitely "hateful" on the ward. The outcome was a chronic dilapidating illness requiring State Hospital care.
>
> From the few facts recited above and sundry other observations in my own and, mediately, other psychiatrists' work I inferred the theory of malevolent transformation of "personality," now taught in the Washington School of Psychiatry, after considerable supporting evidence as to its *current adequacy* had been derived from data on personality development.
>
> In brief, this theory holds that if one progresses into a relatively enduring situation in which one's indicated needs for tenderness are customarily rebuffed, one comes to manifest malevolent behavior when one needs tenderness, in lieu of showing the need, and to expect—and by this pattern all but guarantee —an unfavorable attitude towards one in others. (6, pp. 451–52)

The purpose of the malevolent transformation, we assume, is to avoid the intense anxiety created by the patient's tender feelings. These patients apparently have come to expect that loving feelings in themselves or in others are the prelude to anxiety and rejection. The reflexes of bitter distrust resolve this dilemma very nicely. Such reflexes ward off one's own trustful feelings and tend to push away the other person.

In moderate intensity the "44" security operations of rebellious skepticism have certain adaptive advantages for the individual and for society. They are associated with a healthy, critical approach to the accepted conventions and to the accepted forms of social relationship. There is a familiar observation that every creative expression is an act of rebellion, a critical questioning of some conventional concept. Skepticism gives the human being a sense of freedom and uniqueness. It protects against surprises. A mildly disappointed cynicism is an excellent preparation for future disappointments.

The critical, rebellious person can play a most healthy role in any social group. Docile inertia or fearful-need-to-conform or need-to-be-liked can lead to a stultifying atmosphere. There are valuable rewards for the successful rebel who maintains a realistic, accurate skepticism toward the accepted ways of doing things.

James Joyce has provided an interesting illustration of this relationship between bitter rebellion and creativity. When his hero dedicates his life to art he adopts the motto *non credo, non serviam* and recognizes that this rejection of family, church, and society commits him to a life of "silence, exile and cunning."

The "44" mode of adjustment has been eulogized by many writers. Its most enthusiastic advocate is Robert Lindner. He states: "It is possible, then, to escape from history, to break out of the cage whose outer limits never have worn smooth and deeply grooved with endless pacing. And it is possible to do this without the letting of blood, without violence, without the sacrifice of basic values. All that is required is to reach for one cup wherein the heady mixture of true rebellion, the brew of sweet life-affirming protest, has been poured, for *this*—and this alone— is the *elixir vitae*." (3, p. 296)

This author has taken one mode of adjustment (at one level of personality) and has made it the key to mental health. In the Kaiser Foundation system, the overt reflex security operation of rebellious nonconformity is one of eight generic security operations, each of which has an adaptive and a maladaptive intensity.

Skeptical alienation from convention and from acceptance of others can serve several purposes for the individual who selects this way of

life. These include: protection for disappointment, realistic critical rejection of the conventional, the warding off of anxiety generated by trust and tenderness, the freedom associated with uniqueness and rebellious individuality, and, in the pathological extreme, malevolent retaliation for the feelings of rejection by society in general or specific "other ones."

The Effect of Distrustful Behavior

Bitter rebellious behavior pulls punitive rejection and superiority from others. In systematic language, *FG* provokes *BCD;* crime provokes punishment.

In the passage just quoted Sullivan has described this phenomenon very clearly. He speaks of this pattern almost guaranteeing an unfavorable attitude in others. A sour, distrustful approach invariably establishes distance from others, provoking them to ignore, condemn, or disaffiliate.

In the case of the adaptively, moderately rebellious person the same reaction develops to a milder degree. We consider here the individual who communicates in his actions, his demeanor, and his interpersonal reflexes a message of skepticism and passive rejection of conventionality. These persons are seen as iconoclastic, eccentric, different, creative. Originality is inevitably linked to rebellion, i.e., rejection of the established, the authoritative, the conventional. The iconoclastic approach usually pulls irritated rejection from those who represent authority and from those who conform to it.

One of the most consistent and interesting results of the Kaiser Foundation research has been the empirical importance attached to the conformity-nonconformity axis of the interpersonal diagnostic circle. Conventionality (as measured by the points *L, M,* and *N* on the circle at Levels I and II) is closely related to absence of overt anxiety, to the presence of psychosomatic symptoms, to a state of low motivation for psychotherapy, and to many other personality variables (see Chapter 18). The nonconventional operations of distrust, rebellion, and alienation are defined by the opposite end of the *LMN* axis, i.e., by the points *F* and *G* on the circle.

The individuals whose overt operations emphasize nonconformity and skeptical distrust invariably isolate and alienate themselves from others. Conventional people are often irritated and made anxious by the sullen rebel. Even the most agreeable and overtly friendly souls can be provoked to disapproval when faced with distrustful operations.

The psychotherapy group provides an excellent locale for observ-

ing these processes. Group members are quickly trained to reject or isolate themselves from the sullen patient. By their tone of voice, their gestures, often by their dress, these patients communicate the message, "I am different; I distrust and disagree with you."

The principle of reciprocal relations operates in the case of the rebellious personality with impressive and depressing results. These patients provoke disregard and hostility from others. This behavior on the part of others leads to an increase in retaliatory distrust. The sullen, distrustful person creates for himself a world of punitive rejection.

These reciprocal processes do not work with uniform consistency. There are some individuals who are so committed to friendly, nurturant responses that they do not immediately react with hostility when faced with distrustful reflexes in another. They may attempt to win the sullen person over into a close relationship. Where the rebellious façade is adaptable and not extreme, this may lead to a relaxation of the distrustful defenses. This often happens in social and therapeutic experiences.

Where the distrustful reflexes are intense and are the sole means of warding off anxiety, then positive feelings in the "other one" tend to be rebuffed. This bitter reaction will eventually discourage the most persistently friendly "other" and will inevitably lead to irritation.

The severely distrustful person is most comfortable when he is expressing bitter feelings. He is threatened and suspicious of tenderness which can be viewed as an intolerable threat to his mode of adjustment. The common assumption that what the deprived, distrustful person needs is love and affection can be seen to be a well-meaning but naïve notion. To the person with a set of severely crippled reflexes tenderness in the "other one" is a loaded gun—a most frightening and fearful stimulus. The "malevolent transformation" described by Sullivan is often the reaction to the threat of affection.

D. H. Lawrence has provided us with a clear illustration of the way in which the distrustful, disaffiliated person avoids tender feelings. The hero of *Aaron's Rod* announces: "I don't want my Fate or my Providence to treat me well. I don't want kindness or love. I don't believe in harmony and people loving one another. I believe in the fight and in nothing else. I believe in the fight which is in everything. And if it is a question of women, I believe in the fight of love, even if it blinds me. And if it is a question of the world, I believe in fighting it and in having it hate me, even if it breaks my legs. I want the world to hate me, because I can't bear the thought that it might love me. For of all things love is the most deadly to me, and especially from such a repulsive world as I think this is. . . ." (1, pp. 307–8)

Clinical Manifestation of Distrust and Rebellion [2]

The symptomatic correlates of this mode of overt adjustment are quite typical, and clearly different from other diagnostic types.

These patients exhibit sour, pessimistic, or indifferent feelings. This may often appear to be a *flat affect* or an absence of feelings. This is probably an incomplete and misguided interpretation. There is no evidence to indicate that the distrustful person feels less intensely. It is necessary to look at the interpersonal implications of a resigned or skeptical approach. These patients do not admit to conventional reactions. Their nonconformist façade means that they express different feelings in different ways. They are communicating by their actions and their verbalizations an intense and emotionally loaded message of sullen distrust.

Clinically this attitude may be expressed in the generic motto: "I am a sullen, disappointed person; you can't do anything for me."

These patients do not participate in therapeutic planning with docile eagerness or enthusiastic hope. They may agree to treatment, but the note of skeptical passive resistance is often obvious.

In regard to symptoms, these patients tend not to have psychosomatic ailments;[3] nor do they complain of the overt anxiety of the phobic or the worries of the obsessive. They present characterological or straightforward interpersonal disorders. They tend to complain of marital discord, social isolation, frustration, distance and disappointment in their relations with others. A most typical symptom is occupational or academic difficulty. They may describe a history of rebellion against authority, and are often stalemated in their vocation. They are frank to admit their disillusionment and irritation with others. They tend to complain of their treatment at the hands of others; yet, in contrast to some of the poignant masochists described in the follow-

[2] In this section and in the "Clinical Manifestation" sections of the following seven chapters, we shall consider the symptomatic pictures presented by the various diagnostic types. These discussions are highly generalized and suggestive. Two qualifications must be kept in mind. First, we are considering here the symptomatic picture of the pure type (in this chapter the "44"). Variations in behavior at other levels can change the symptomatic presentation; thus, the "41" comes to the clinic presenting a façade different from the "44." The second qualification refers to the precipitating cause for psychiatric referral. Most of the patients coming to the psychiatric clinic are in some state of anxiety. Often something has happened recently to threaten their overt security operations (whether they are schizoid or hysterical). We are considering, in this section, the general clinical impression made by the patient which is often quite different from the "current" anxiety which brings him to the clinic.

[3] In one diagnostic study comparing the Level I interpersonal diagnoses of a group of psychosomatic and neurotic patients, only 7 per cent of the psychosomatics fell into the rebellious-distrustful octant (*FC*) of the diagnostic grid, whereas 43 per cent fell into the opposite sector. (2)

ing chapter, they do not attempt to win pity or to present themselves as good and blameless. They stress instead a grievance against the world, a pessimistic disappointment with self and others.

These security operations, it will be noted, do not lend themselves to a well-motivated, eager acceptance of psychotherapy. They often agree to treatment with a half-hearted pessimism: "I guess I'll have to; I don't see any other solution," etc. These patients often express passive complaints about the kind of therapy offered, about the therapist to whom they are assigned, about the necessity to be in a clinic, etc. Often these patients will sullenly refuse the therapy that is recommended. For example, they may interpret the assignment to group therapy as a sign of rejection by the clinic.

In the case of the moderate rebel, these gloomy, resistant operations may not become apparent. They may employ a sarcastic, self-immolating humor. They may describe their isolation and disappointment with a bitter, wry irony. If they sense honesty and reasonability in the clinician they may muffle or shelve their skepticism.

Regardless of the intensity or rigidity of the character structure, there is one interpersonal rule which invariably holds for the "44" personality. They are painfully sensitive to phoniness, pomposity, naïve obtuseness, or arrogance on the part of the "other one." These patients tend, as a group, to load their perceptions of others with a hostile skepticism. They look for dishonesty and hostility in others. They are incredibly sensitive instruments for picking up rejection or punitive feelings in others. Naïve hysterical patients, on the contrary, tend to act on the assumption that others (in their in-group) are conventional and sweet like themselves.

We have noted in Chapter 7 that all maladjusted persons are skilled in provoking others to certain reciprocal responses. The distrustful patient is most accomplished in pulling bureaucratic or moral disapproval from others. He often puts the therapist to elaborate tests aimed at provoking impatience or moral censure. He compulsively clings to the often automatic and involuntary conviction that the clinician fails to understand him, or acts in a pompous, overconventional manner. He specializes in provoking the therapist to set limits and re-create an authority-rebellion or rejecting-distrustful relationship.

The distrustful "44" personality type described in this chapter has certain similarities to a behavior pattern observed in group psychotherapy by Jerome Frank *et al.* (5, pp. 215) Frank calls this type the "help-rejecting complainer" and states that the pattern "consists of a patient's continuing attempt in the group to elicit help—often without actually asking for it—and his attempt to prove greater need than

other people, while either implicitly or explicitly rejecting all help offered. This pattern seems to be an expression of conflict between the patient's perception of himself as needing help and his anger at all potential help-givers for being unable or unwilling to supply it. His behavior justifies his anger toward the help-givers and maintains his claim for help while preventing him from becoming dependent on the distrusted potential help-givers."

We have so far stressed the symptomatic and interpersonal aspects of the clinical picture. There are certain psychometric correlates of the rebellious presentation which appear on personality tests—for example, the MMPI and the Rorschach—which are independent of the interpersonal system.

Patients who behave in a sullen, distrustful manner (Level I) have a typical pattern on the MMPI. Their high peaks fall on depression, schizoid, and psychopathic scales. They also have elevations on the F scale which is a rough measure of nonconformity. They generally do not have elevations on the L, K, Hy, and Hs scales.

This suggests that pessimistic dysphoria (D), alienation (Sc), rebellious disidentification (Pd), and nonconventionality (F) are characteristics of the distrustful personality. The scales on which they show low scores are those related to denial of antisocial or hostile tendencies and to a naïve, conventional, sweet façade. The distrustful personality can be differentiated on the MMPI from the obsessive-masochist. The latter have pronounced depression and psychasthenic scales. The former exhibit schizoid scores which are higher than psychasthenia; and, though the depression scores are elevated, they are not as marked. The higher the F, the more likely that rebellion and not masochism is the security operation.

On the Rorschach or TAT these patients characteristically manifest different, odd, idiosyncratic content. Unconventional themes are common—bizarre situations, freely described sexual themes, and poor form responses.

Interpersonal Definition of the Schizoid Maladjustment

Chapter 12 presented evidence that certain standard psychiatric diagnoses were related to specific interpersonal patterns. Extreme, imbalanced social patterns thus can help to establish psychiatric diagnosis.

Distrustful, intensely rebellious behavior is characteristic of the *schizoid* personality. Such a personality shows maladjustment essentially in bitter, disappointed alienation and tends to handle anxiety by avoiding close, tender contacts with other individuals and by avoiding close commitments to society in general. In the extreme case this be-

comes a malevolent rejection of people and of conventional social standards.

Many of the symptoms of the schizoid condition may be interpreted in the light of interpersonal communication. They seem to be expressions of a bitter alienation from accepted standards, a refusal to conform which in the extreme case becomes a rigid pathological inability to conform. Highly individualistic, eccentric behavior is (in the absence of organic disease) generally pathognomonic of schizophrenia. It seems possible to think of this as being an intense, and often desperate, attempt to express difference, to establish a complete, bitter break from conventional reality.

Kobler, speaking from therapeutic experience with schizophrenics in the Pinel Foundation Hospital, believes that schizoid malevolence can be seen as asking the question, "Even if I do this and am like this, can you still love me?" The therapeutic staff at Pinel senses hope and a violent testing of the therapist with the anticipation of, "No, the other cannot love." When the reaction of the therapist is not rejection, Kobler states that there is further negativistic testing and at the same time the continued hope of finally finding the one who will not reject.

The Schizoid Psychosis

The interpersonal effect of bizarre behavior is to provoke exasperated rejection from others. Marked eccentricity flaunts to the world the message, "I do not accept your ideals of conduct; I do not conform. I do not want your approval." This usually guarantees to the subject the disapproval of others. In the extreme case (psychosis) it provokes society to punitive incarceration.

The tendency for bizarre behavior to pull rejection from others was illustrated by the reactions of some therapy group members to the schizoid fantasies of a fellow member. This particular group had been meeting for almost a year and an unusually frank, honest recognition and acceptance of each other had been developed. One of the members was a chronic, severe, ex-state-hospital schizoid who had apparently never been able to integrate a friendly, trusting relationship with another human being. The group had initially ignored and despised her. By the fourth month, her ability to train others to reject her was the focus of considerable study. Even after this had been worked through for two more months, she could be reduced to panic by a warm smile or casual friendly compliment.

In one session a woman who employed narcissistic, exhibitionistic operations described her fantasy of parading down the street in glamorous clothes in order to provoke envy and admiration from others.

The schizoid woman then confided the repeated fantasy of running naked out into the street. The question was then posed to the group what reaction would be provoked from them at the sight of a neighbor running naked in the street. Their associations were, "I'd think she's nuts," "I'd call the cops to come and take her away," etc. These associations demonstrated the effect of the bizarre fantasy in pulling rejection and intolerant contempt from others. Expressed in the context of an honest and accepting group they sharpened the schizoid patient's understanding of the rebellious and alienating effect of her security operations.

Many schizoid or schizophrenic symptoms can be interpreted as interpersonal communications conveying to others the theme of malevolent disaffiliation. The inability or refusal to integrate close relations with others and the tendency to perceive and react differently have such a consistent and inevitable impact on others that they seem to confirm the hypothesis that an interpersonal purpose is involved. In the extreme case these desperate violations of customs and accepted social patterns become the symptoms of psychotic negativism; autism, incontinence, refusal to eat, etc. The bitter, rebellious anger involved in these behaviors has often been commented on by clinicians.

Some interesting complications are introduced by cultural differences. A schizophrenic psychosis is defined as a desperate, repetitious, malevolent, distrustful rebellion. Now, the behaviors which express these motives may differ from one society to another. Thus, failure to eat and an insistence upon the reality of one's own fantasy life are, in our society, negativistic and alienating behaviors. In another society the same behavior may be symptomatic of an extreme desperate attempt to overconform. It may express the message of frantic religious overconventionality. The interpersonal effect of the symptom is the key to its diagnostic meaning.

A glance at the symptomatic signs of schizophrenia listed in any psychiatric text seems to suggest that most of them are calculated to provoke frustration and irritation in others. The symptoms of the obsessive state, by comparison, tend to provoke feelings of superiority in the other one.

The rebellious implication of the schizoid maladjustment has been noted by other writers. Powdermaker for example writes:

> Why does the schizophrenic use the particular defenses that he does against these fears and conflicts? Why does he make himself ununderstandable and so different from the social norm in his relationships, instead of endeavoring to conform to the social norm as the neurotic does? That the schizophrenic is an unsuccessful rebel appears to be one of the outstanding aspects of his behavior. This was pointed out in the work of Ackerly, in which he showed how the de-

linquent acts of some of his adolescent patients had saved them from a probable schizophrenic breakdown. (4, pp. 61–62)

Research Findings Characteristic of the Distrustful Personality

Here is a summary of some of the studies accomplished on the schizoid personality by the Kaiser Foundation project.

1. Patients who exhibit rebellious distrust in their overt operations do not tend to have psychosomatic symptoms.

2. Psychosomatic patients do not tend to utilize these interpersonal operations at Levels I or II.

3. Distrust at Levels I and II is related to depression (D), nonconformity (F), schizoid tendencies (Sc), and rebellious disidentification (Pd) on the MMPI.

4. These patients are among the initially best motivated for psychotherapy. They do not tend to terminate their clinic contacts after evaluation but are likely to go on into treatment and to remain in treatment.

5. They are (along with the psychopathic personalities) the most consciously disidentified with their mothers and their fathers.

6. They tend as a group to be extremely disidentified with their spouses.

7. They (along with the psychopathic personalities) show a tendency to misperceive the interpersonal behavior of others. They are inclined to attribute too much hostility to others.

8. Considering all the eight diagnostic types (at Level I), the schizoid group comprises the largest number of unmarried individuals. This suggests that more schizoid patients than patients of any other diagnostic type have failed to accomplish a durable, conventional mating relationship.

9. The schizoid personality tends to appear in certain cultural and institutional samples much more frequently than others. The percentage of rebellious individuals (Level I-M) in various samples is presented in Table 16. The percentage figure expected by chance for these groups is 12.5. It will be noted that eight groups contain more than or close to the expected number of rebellious-distrustful personalities—the four psychiatric samples, the graduate student, the overtly neurotic dermatitis, the prisoner, and the psychotic samples. All but two of these define "people in trouble," i.e., at odds with or maladjusted to society. The fact that the graduate student sample contains a higher percentage of schizoid personalities than the more conventional groups suggests that rebelliousness is a characteristic of this sample. This is an interesting confirmation of the hypothesis that creativity, delinquency, and alienation involve somewhat similar security

TABLE 16

PERCENTAGE OF REBELLIOUS-DISTRUSTFUL PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Rebellious-Distrustful Personalities*
Psychiatric Clinic Admission	537	12
College Undergraduates	415	3
University Psychiatric Clinic	133	22
Middle Class Obese Patients (Female)	121	3
Overtly Neurotic Dermatitis Patients	31	13
Self-Inflicted Dermatitis Patients	57	7
Unanxious Dermatitis Patients	71	3
Group Psychotherapy Patients	109	24
Individual Psychotherapy Patients	49	12
Hypertensive Patients	49	0
Ulcer Patients	43	0
Medical Control Patients	37	3
University Counseling Center	93	4
University Graduate Students (Male)	39	13
Stockade Prisoners (Male)	52	10
Hospitalized Psychotic Patients	28	14
Officers in Military Service	39	3
Total	1903	

operations—rebelliousness toward conventionality. The overtly neurotic dermatitis sample differs from the other psychosomatic groups in the amount of bitter, masochistic behavior manifested. Rebellious-distrustful patients comprise the largest percentage of patients who enter and remain in group therapy at the Kaiser Foundation clinic. One out of every four patients (24 per cent) entering group therapy were schizoid personalities. Two factors are suggested to account for this finding. The clinic intake conference has found that group therapy is the most effective therapeutic agent for patients who are isolated, distrustful, and distant from others. Thus, the clinicians refer more schizoid patients to groups. Obsessives and phobic patients, on the contrary, are more likely to be referred to individual treatment.

A second possible explanation for this finding is that schizoid personalities tend to remain in therapy because the diffused and diluted transference phenomena in the group are less intense than the transference of individual therapy. These distrustful people can apparently stand the interpersonal pressure in the groups where they can remain silent or sullen for considerable periods without completely disrupting the therapeutic process.

10. The percentage of subjects who diagnose themselves as rebellious-distrustful (Level II-C) is presented in Table 17. These findings tend to be in line with the Level I-M data just discussed. Group

TABLE 17

PERCENTAGE OF REBELLIOUS-DISTRUSTFUL PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Rebellious-Distrustful Personalities*
Psychiatric Clinic Admissions	207	10
Hospitalized Psychotic Patients (Male)	46	11
Group Psychotherapy Patients	101	20
Individual Psychotherapy Patients	38	5
Overtly Neurotic Dermatitis Patients	31	13
Self-Inflicted Dermatitis Patients	56	9
Unanxious Dermatitis Patients	70	6
Medical Control Patients	41	7
Ulcer Patients	42	7
Hypertensive Patients	49	0
Middle Class Obese Patients (Female)	100	0
Total	781	

psychotherapy patients again comprise the largest percentage of schizoid cases. Overtly neurotic dermatitis patients, again, differ from the other psychosomatic groups in the emphasis on bitter behavior.

11. Schizoid patients consciously perceive their parents to be weak and distrustful people. The mean placement of fathers of schizoid patients is in the *FG* section of the diagnostic grid. Mothers locate in the guilty, self-punitive (*HI*) sector. Schizoid patients report their marital partners as strong and exploitive.

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16

Adjustment Through Self-Effacement: The Masochistic Personality

We are considering in this chapter the many personality types which, despite their multilevel differences, have one important thing in common—they all present in their overt operations a façade of self-effacement. This is the "55" personality type.

The message which they communicate to others in their face-to-face relations is "I am a weak, inferior person." Through their automatic reflex operations they train others to look down upon them with varying intensities of derogation and superiority.

The mild form of this security operation is manifested as a modest, unpretentious reserve. In its maladaptive extremes it becomes a masochistic self-abasement. In either case the person employing this general mechanism avoids anxiety by means of retiring, embarrassed diffidence. He is automatically mobilized to shun the appearance of outward strength and pride.

The Purpose of Self-Depreciation

The individuals who employ this security operation do so because they feel that this social role is the safest and least dangerous position to be assumed in this particular situation. Now persons vary in the consistency with which they employ any interpersonal behavior. Some repetitiously respond with the same reflexes in almost all situations, whether appropriate or not. Others may automatically assume modest, retiring reflexes in particular situations where they expect it to be appropriate. Many subjects, for example, act embarrassed and reserved when facing strong and potentially dangerous others.

In this chapter we are considering those patients who present a façade of guilty submissiveness in their approach to the clinic. We cannot assume, of course, that all these patients act in this way in all

their life relationships. We simply know that this is their interpersonal impact on the clinic. It is, therefore, the aspect of their personality that we must begin to respond to and deal with.

Whenever we observe or measure this security operation, we may assume that an individual has learned to employ self-depreciation as a protective device in certain situations, or in all situations. Later investigation (e.g., measurements at other levels) will indicate the range and consistency of this security operation.

The role of masochism in contributing to the security of the individuals has been pointed out by several psychoanalytic authors. Menaker has contributed an excellent summary of these theories:

> The observation that masochism is a way of avoiding anxiety, a point on which a number of analysts agree, is a clue to the fact that one of its important aspects is its function of defending the ego. Important psychoanalytic contributions to the understanding of masochism, however, have thus far been too exclusively concerned with its libidinal meaning. The point of departure has been how gratification is achieved for the individual through masochistic behavior, rather than examining the way in which it serves the ego.
>
> We find that viewing the problem of masochism from the standpoint of the self-preservative functions of the ego leads to new insights. As might be expected, the ego function of the masochistic attitude is most clearly discernible in the study of moral masochism. Berliner, confining his observations primarily to moral masochism, has made an important contribution to the concept of masochism as a defense mechanism of the ego. He takes masochism out of the sphere of the instincts and views it as a function of the ego. It is 'a pathologic way of loving' in which the ego through processes of introjection, identification and superego formation turns the sadism of the love object (not its own sadism) on itself. The motivation for so doing is the need to cling to a vitally needed love object. The dependent child accepts the suffering emanating from the rejecting love object as if it were love, failing to be conscious of, or denying the difference between, love and hate. Once the hating love object has become part of the superego, the constant wish to please and placate the superego causes the individual to lose his identity and to 'make himself as unlovable as he feels the parent wants him to be.'
>
> Analytic experience confirms Berliner's view of masochism as a function of the ego in the service of maintaining a vitally needed love relationship to a primary object. (4 pp. 207–8)

The general purpose of the masochistic mechanism seems to involve the warding off of anxiety by means of self-depreciation. The more specific meanings of the mechanism vary from case to case depending on the multilevel pattern.

The fact that the rather shallow methodology of the interpersonal system defines several thousand types which express masochism at one or more levels of personality testifies to the difficulty of making broad generalizations about the specific meaning of masochism. The pattern

of conscious and "preconscious" identifications give different interpretations of self-punitive behavior. The introjection patterns are also crucial in some cases. We have developed one hypothesis which is in line with the psychoanalytic theories summarized above. It seems logical to assume that wherever masochism is expressed at any level of personality, then sadistic feelings are also present. These may be attributed to the conscious or "preconscious" perceptions of others or they may be restricted to deeper levels of "self-behavior." Guilt does not exist without some introjection or underlying acceptance of punitive themes. Self-criticism seems inevitably to involve some aspect of hostile criticism expressed against or projected on others.

It must be kept clear that we are discussing involuntary reflexes at this point. We are not referring to the conscious, deliberate assuming of a humble role—nor to the expression of modest words (i.e., Level II humility); we are thinking rather of automatic tendencies to handle insecurity by means of weak, depressive, shy operations.

The Effect of the "55" Security Operations

Self-effacement pulls depreciation and patronizing superiority from others. (In the code-language of the interpersonal system, *HI* pulls *BC* and *DE* from others.) That is to say, if a person acts in a glum, guilty, withdrawn, and weak manner, he will tend to train others to look down on him and to view him with varying amounts of contempt.

One interesting expression of masochistic behavior which invariably provokes others to scorn is the "buffoon" personality. One psychoanalytic interpretation of the interpersonal meaning of the clown's behavior points to the assumption of the castrated role. According to Grotjohn (1) the clown in his dress, gestures, and thematic expressions is telling the audience: "I am a harmless, weak, defeated person." The social buffoon seems to exhibit his shameful, inferior position and to force the onlookers to laugh at him and to patronize him.

The reciprocal interaction does not occur in every case. The phenomenon of reciprocity is, as we have seen in Chapter 7, a probability statement. Self-derogation sometimes pulls initial sympathy, but if the guilty reflex does not shift in response to this positive reaction, the "other one" will inevitably respond with irritation and disapproval. Another factor preventing the reciprocal process from invariably working resides in the personality of the "other one." If a modest person, or a buffoon, is dealing with a rigidly docile "other"—the latter may not respond with superiority and disdain. In general these relationships do not remain durable since the self-depreciator tends to gravitate away from "equal" relationships and to prove rejection by means of withdrawal. The docile person tends also to avoid

equal relationships and to seek strong, guiding partners. If two individuals with submissive façades maintain a durable relationship, it will generally be found that a reciprocity of underlying themes (often of a competitive or depreciatory nature) is preserving the interaction.

Self-abasing individuals provoke punitive and arrogantly superior reactions from others. Most persons do not prefer to maintain relationships with weak, guilty people. They tend to look down on the masochists when they encounter them and do not enter into durable interactions.

While most people avoid the masochists, there are, however, some dramatic exceptions to this rule. By the systematic and statistical logic of the interpersonal circle, one quarter of the population is bound to fall into the upper left-hand quadrant. This is the area which includes the operations of exploitation (*C*), narcissism (*B*), and punitive hostility (*D*). These individuals provoke fear, envy, and guilt in others. The modest masochist, we have seen, trains others to reject and despise him. The beautiful interlocking of reciprocal reflexes which occurs in the relationship between these two types is, of course, one of the most familiar problems in dynamic psychology.

Self-effacing, guilty individuals feel the least anxiety when they are manifesting their masochistic reflexes. They therefore gravitate to and stay with those individuals who will provoke the least anxiety—the aggressive, exploitive characters from the upper left part of the diagnostic grid.

This reciprocal phenomenon is seen over and over again in the maladaptive masochistic marriage—the overtly sorrowful, martyred, abasive wife hopelessly entangled with the brutal husband—or the overtly shy, timid man wearing himself out in service of the exploitive, narcissistic wife.

This exchange of guilt and superiority also exists with remarkable frequency in the relationships of normal, adaptive individuals. One individual takes the modest, inferior, self-effacing part, while the other exercises the superior role—to the comfort of both. Such reciprocal relations are generally complicated by underlying motives. We are discussing in this section the general aspects of the modest masochistic security technique as exhibited in overt interpersonal reflexes. We shall therefore postpone the detailed discussion of the multilevel patterns which usually underly the self-abasive façade.

Level I modesty and self-depreciation can be adaptive or rigid, maladaptive responses. Their purpose is to ward off anxiety. They lead to the counterreactions of depreciation and superiority on the part of the "other one." Extreme, rigid masochism invariably sets up new chains of conflict and increased anxiety which can be responded to by

increased repetition of self-abasement, by related symptomatology, and by other signs of psychic distress.

We shall now consider some of the clinical manifestations, both interpersonal and symptomatological, of the modest-masochistic personality.

Clinical Definition of the "55" Personality

The symptomatic, clinical aspects of the overtly self-effacing personality are easily described. The outstanding symptom is depression. These people are overtly anxious and unhappy. They exhibit guilt and self-depreciation. Doubt, rumination, and obsessive uncertainty are emphasized. Associated with this is an immobilized passivity.

They are not active or self-confident. They are not assertive or reasonable. They do not challenge or compete with the clinician.

Their interpersonal impact on others involves weakness. They often admit their need for psychotherapy. They tend to make the clinician feel comfortable in his role because they readily assume the position of a patient. These are the patients who keep the clinics in business.

These patients are often riddled by guilty, obsessive thinking. Hecht's investigation of the masochistic personality revealed that obsessive rumination (as measured by the MMPI) had an important diagnostic relationship to self-effacement (2). This has been confirmed repeatedly by our own studies, which have revealed a correlation between obsessive thinking and self-depreciating behavior.

When a patient comes to the clinic emphasizing such messages as "People are mean to me," "I have done wrong," "I am unworthy," and "I am inferior," then the presenting operations of masochism can be suspected. The effect of this approach is to make the other one feel strong, slightly superior, perhaps, and initially supportive. The superior reaction of the clinician is often bound up in his therapeutic role so that he may not be aware that this response is being pulled from him. The untrained clinician is often provoked to sympathetic gestures. The more sophisticated diagnostician is usually struck by the force of the self-punitive superego.

This brings us to another aspect of this personality type—the moralistic quality of their self-reproaches. The masochistic, guilty patient is generally obsessed with matters of "right and wrong" and measures himself (to his own disadvantage) against his own strict ideals. This point is clearly demonstrated by the finding that the sector of the diagnostic circle which defines self-effacement is the farthest removed from the standard ego-ideal image of our culture. Their behavior is rated in the *HI* sector of the circle—whereas the ego ideal is

invariably located in the opposite sectors. These patients are dissatisfied with themselves, and this is, of course, related to their relatively high motivation for psychotherapy.

In their social demeanor these patients typically tend to be silent, fearful, and unsociable. In the moderately self-effacing person this may be seen as a modest reserve. In severe cases it becomes a marked withdrawal.

Obsessive Neurosis and Self-Effacement

The self-effacing personality manifests the symptoms of depression, immobilization, and ruminative self-doubt. Patients whose overt interpersonal behavior is masochistic or self-derogatory are often given the standard psychiatric diagnosis of obsessive neurotic. In Chapter 12 common clinical diagnostic categories were compared to interpersonal types. Evidence was cited which showed that the *HI* sector of the circle at Level II was related to the familiar obsessive category. Research on Level I behavior has confirmed this finding. Patients who were diagnosed by fellow group patients as falling in the masochistic sector of the circle invariably manifested the symptoms of the obsessional disorder. On the MMPI these patients have their highest scores on the depression and psychasthenia scales—which are generally seen as diagnostic of obsessional processes.

Several correlation studies between MMPI scales and Level I behavior have been reported (3). When the depression and psychasthenia scales are correlated with the Level I-S vertical index, significant negative correlations with dominance are consistently obtained. Depression and worry are related to passivity.

There is considerable research evidence pointing to a relationship between the interpersonal security operation of masochism and obsessive symptoms and clinical diagnosis of obsessive neurosis. In addition, there are some theoretical links between masochism and the obsessive process. When this relationship was first suggested by our data, there was considerable question on the part of the research staff, as well as the advising clinicians, as to the accuracy of tying masochism to obsessiveness.

Subsequent diagnostic work has tended to confirm the relationship and has shed some light on its possible theoretical meaning. The linking factor seems to concern guilt and self-derogation. It is generally accepted that the obsessive symptoms—rumination, concern with right and wrong, self-doubt, etc.—are connected with guilt. So is masochism. It seems to make clinical and theoretical sense that self-effacement is the interpersonal expression, and obsessiveness the symptomatic expression of the same overt security operation.

The Obsessive-Compulsive Phenomenon

The relationship between the interpersonal security operations of self-effacement and the standard symptomatic diagnosis of "obsessive" raises an interesting terminological issue. Obsessions have to do with persistent ideas, intellectual preoccupations, doubts, worries, guilty thoughts. These generally lead to inhibition of action—expressive, spontaneous action in particular. Obsessiveness is typically accompanied by indecisiveness and depressive immobilization. The interpersonal correlate of obsessiveness is modest passivity and self-punitive timidity. Worried rumination communicates the interpersonal message, "I am unsure, fearful, self-doubting."

Compulsions have generally been distinguished from obsessions. Compulsions are repetitive activities, e.g., promptness, orderliness, precise activity, disciplined behavior. Compulsions often have an interpersonal impact quite different from obsessiveness. Compulsive individuals are often not indecisively immobilized; they expend a great deal of energy in exact, demanding action. They often communicate not an interpersonal message of doubt or fear, but, on the contrary, one of righteous self-satisfaction, pedantry, and superiority. It seems in some cases that when compulsions are successfully executed they express the opposite interpersonal meaning of obsessive behavior.

Obsessive and compulsive behavior are traditionally linked in psychiatric terminology. The terms are often used synonymously. In most diagnostic texts the two are considered together and a paradoxical mixture of symptomatic cues is lumped together. Worried self-doubt and pedantic superiority are often cited together as diagnostic cues for the same personality type. From the standpoint of descriptive or symptomatic psychiatry these inconsistencies do not appear too striking; but when they are viewed from the position of interpersonal theory, the paradoxical and dichotomous nature of the obsessive-compulsive syndrome comes sharply into focus.

The interpersonal meaning of *successful* compulsivity is, "I am right and superior." The interpersonal meaning of *pure* obsessiveness is, "I am wrong and unsure."

The general practice of combining these two opposing security operations is a confusing and inefficient terminological practice. The functional meaning of rigid compulsivity is quite different from that of pure obsessiveness, and different from both of these are the many cases which show alternations of both behaviors. *Obsessive-compulsive* is hyphenated because the two elements appear to be opposing, dichotomous factors; they are diametrically different ways of handling guilt and weakness. *Sado-masochism* is another familiar hyphe-

nated term in psychiatry. These two elements are also linked because they are diametrically opposite ways of dealing with hostility. Clinicians seem to recognize, however, that although sadism and masochism are reciprocally related, the two words are not synonymous. It is of crucial importance to know which side of a sado-masochistic conflict is overt and which is underlying. The functional problems involved in getting an overtly sadistic personality into therapy are quite distinct from those involving the overt masochist. The latter is often initially better motivated.

It is useful to make the same distinction in the case of the obsessive-compulsive phenomenon—that is, to determine specifically whether a patient is presenting overtly as an obsessive, guilt-ridden, depressed person, or whether compulsive defenses are successfully operating. In the latter case the patient is outwardly active, more self-confident, and manifests a righteous, active façade.

Many cases seen in the psychiatric clinic show mixtures of obsessive-compulsive symptoms. In the interpersonal language they may be guilty and self-effacing at Level I-M, but this may be seen as a temporary breakdown of a compulsive personality. Often Level I-M may be depressed and masochistic while the Level II self-description emphasizes managerial, responsible themes. This indicates that the compulsive defenses are weakening; guilt and weakness in the form of symptoms are breaking through.

Arthur Kobler of the Pinel Foundation Hospital has added an important qualification to the point being made in this section. He believes that the distinction between the interpersonal implication of obsessive versus compulsive behavior may hold for the popular, adjusting aspect of compulsivity. He states, however, that severe compulsive rituals—"driven actions with magical quality"—are closer to obsessiveness. The interpersonal theory would be in strong agreement with this statement because it interprets these bizarre rituals as diagnostic of the schizoid message, "I am different, queer, alienated." Since schizoid behavior in the interpersonal system falls next to obsessiveness on the diagnostic continuum, Kobler's valuable clarification seems to fit the "circle" theory.

To summarize: The distinction between compulsive and obsessive behavior is functionally valuable. Pure compulsivity (where there is no breakthrough of the warded-off, underlying guilt) indicates interpersonal power, pedantry, and self-righteousness. Pure obsessiveness is associated with overt interpersonal passivity and humility. It is possible to use the hyphenated term obsessive-compulsive to refer to multilevel patterns of conflict, but the meaning (symptomatic and interpersonal) of the separate terms should be kept distinct.

Research Findings Characteristic of the Self-Effacing–Masochistic Personality

The characteristics of the masochistic personality which have just been discussed are based on research findings of the Kaiser Foundation project. These have been described in other publications. Some of these findings will now be summarized.

1. Patients who exhibit masochistic operations at Levels I and II do not tend to have psychosomatic disorders, except for the overtly neurotic dermatological symptom groups (acne, seborrheic dermatitis, and psoriasis).

2. Psychosomatic patients do not present self-punitive behavior in their overt operations, except for the above-listed skin disorders.

3. Patients who express masochism at Level I tend to have MMPI profiles emphasizing obsessive (Pt), depressive (D), and passive (Mf) trends.

4. Self-punitive behavior at Level II is also related to the same MMPI scales.

5. These patients tend to stay in psychotherapy longer than hysteric, managerial, narcissistic, or psychosomatic patients. They tend to stay in therapy about the same length of time as schizoid, phobic, and psychopathic personalities. They belong to the well-motivated group of patients.

TABLE 18

PERCENTAGE OF SELF-EFFACING–MASOCHISTIC PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Self-Effacing–Masochistic Personalities*
Psychiatric Clinic Admission	537	13
College Undergraduates	415	2
University Psychiatric Clinic	133	14
Middle Class Obese Patients (Female)	121	2
Neurodermatitis Cases	112	13
Overtly Neurotic Dermatitis Patients	31	16
Self-Inflicted Dermatitis Patients	57	7
Unanxious Dermatitis Patients	71	7
Individual Psychotherapy Patients	49	22
Hypertensive Patients	49	7
Ulcer Patients	43	3
Medical Control Patients	37	5
University Counseling Center	93	3
University Graduate Students (Male)	39	0
Stockade Prisoners (Male)	52	2
Hospitalized Psychotic Patients	28	11
Officers in Military Service	39	0
Total	1903	

6. They tend to be consciously disidentified with their mothers.
7. They tend to be consciously disidentified with their fathers.
8. They tend to be consciously disidentified with their spouses.
9. The masochistic personality is found most frequently in certain institutional and cultural settings (see Table 18). Masochists appear more often in psychiatric samples and rarely occur in psychosomatic or normal samples. One exception to this statement—certain neurodermatitis groups are more often masochistic (at Level I) than any other psychosomatic sample.
10. The percentage of self-effacing personalities (defined by Level II-C) found in various samples is presented in Table 19.

TABLE 19

PERCENTAGE OF SELF-EFFACING-MASOCHISTIC PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Self-Effacing-Masochistic Personalities*
Psychiatric Clinic Admissions	207	9
Hospitalized Psychotic Patients (Male)	46	6
Group Psychotherapy Patients	101	14
Individual Psychotherapy Patients	38	21
Overtly Neurotic Dermatitis Patients	31	16
Self-Inflicted Dermatitis Patients	56	7
Unanxious Dermatitis Patients	70	4
Medical Control Patients	41	5
Ulcer Patients	42	2
Hypertensive Patients	49	0
Middle Class Obese Patients (Female)	100	3
Total	781	

Neurotics and neurodermatitis patients express the most masochism. Psychosomatic and normal groups the least. It is of interest that the psychotic group manifests considerably less self-effacement than the neurotic samples. The implications of these findings are discussed in Chapters 23 and 24.

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17

Adjustment Through Docility: The Dependent Personality

This chapter is concerned with those individuals who present in their approach to the clinic a façade of dependent, docile conformity. This is the "66" personality type. The interpersonal message it conveys to others is, "I am a meek, admiring person in need of your help and advice."

The moderate form of this security operation is expressed as a respectful or poignant or trustful conformity. In its maladaptive intensity it is manifested as a helpless dependency. These subjects in their interpersonal reflexes avoid the expression of hostility, independence, and power.

The Purpose of Docile Conformity

Human beings utilize these security operations because they have found that they are least anxious when they are outwardly relying on or looking up to others. Some individuals employ these reflexes in their relationships with everyone they contact. Others assume this role when they assume it to be called for by the situation. They act helpless and fearful when dealing with strong individuals, authority figures, and the like.

Many patients automatically assume this role in approaching medical or therapeutic agents. The doctor-patient relationship is loaded with dependency implications. Most patients manifest a certain amount of helpless trust in coming for diagnosis. The normative statistics employed in the interpersonal diagnostic grids are based on large samples of clinic patients. In this chapter therefore we shall be describing those individuals who express more dependency than the average clinic visitor. We have isolated these persons who seem to go out of their way to pull sympathy, help, and direction from others;

who use their symptoms to communicate a helpless, painful, uncertain, frightened, hopeful, dependent passivity.

Now many of these patients exert this interpersonal pressure in the clinic but may act quite differently in other situations. They may be fairly independent in certain social interactions. At other levels of behavior they may be less phobic and docile. The fact that they present dependence as their calling card to the clinic is an indication that this is the functionally critical point at which to begin the diagnostic evaluation. This defines their initial motivation, their first line of defense.

Whenever we observe this security operation, we tend to assume that the patient has come to employ docile dependence as a means of handling anxiety in this type of situation. Further investigations may reveal the flexibility or rigidity of this behavior and may indicate that opposing motives exist at other levels or in other situations.

The Effect of Docile Conformity Upon Others

Docility pulls strong, helpful leadership from others. Dependence provokes nurturance. In the language of the circle, "*JK* pulls *AP* and *NO* from others."

If a person acts in a poignant, helpless, respectful manner, he trains others to offer help, advice, and direction. He who asks tends to get taught. These subjects tell others by means of their reflexes that they are weak-and-friendly. They thereby provoke others to be strong-and-friendly.

These reciprocal tendencies do not occur inevitably but within probability limits. Some punitive individuals react with stern disapproval to dependence in another. Severe masochists are unable to express nurturance even though the other is exerting intense dependent pressure. In general, however, docile individuals tend to be most comfortable when they are involved with strong, responsible individuals. Nurturant people naturally seek admiring, trustful individuals who will respond to and need their help. The docile phobic person tends to irritate the rebel and to threaten the counterphobic; he does not generally integrate durable relations with these individuals. Close symbiotic ties link the meek, admiring (*JK*) individual to respected, helpful (*APNO*) partners.

These reciprocal situations hold for brief encounters as well as durable interpersonal pairings. Poignant, tearful helplessness in the first few seconds of an interaction provokes tenderness and guidance from another. Patients who present these reflexes in an initial psychiatric interview generate forces which may tend to pull assurance from the clinician. Whenever the clinical interviewer finds himself un-

usually inspired to help, to promise, to reassure, to explain, to do something to relieve anxiety and tears, he will generally find that he is dealing with security operations of dependent docility.

The effect of *JK* behavior is, therefore, to train the "other one" to assume a strong, friendly role. Circular chains of interaction, of course, develop. The respected, responsible, nurturant person in turn presses the dependent person to increased dependence. Where these symbiotic tendencies are uncomplicated by underlying conflicts on the part of either partner, a most comfortable durable relationship develops. The passive son attached to a strong nurturant mother provides a typical example of this process. The docile, adoring wife dutifully tied to a responsible, managerial husband is another.

Where the docility is intense and all other reflexes are crippled or where underlying motives conflict with the overt dependence, then anxiety fails to be warded off. This anxiety can be dealt with by increased helplessness, eventually leading to a fairly typical set of psychological symptoms. The neurotic expressions of severe dependent conformity will now be considered.

Clinical Definition of the "66" Personality

The defensive operations of docile conformity, when employed in the intense maladaptive degree, result in a set of specific symptoms which are related to and a logical outcome of the tactics.

The first clinical indication is helplessness and overt anxiety. Clinically this is generally expressed as a marked depression. Fears, worries, elaborate concern over physical or emotional discomfort are common.

A most definitive sign of this personality type is the presence of phobias. The patient is fearful of events or experiences without any direct rational cause. Descriptive psychiatry of the last century has listed dozens of impressive-sounding hyphenated terms denoting the different phobic reactions. While it seems fruitless to recapitulate this list of descriptive labels, it seems worth while to point out that they generally refer to an irrational and inexplicable intense fear of some stimulus—fear of heights, fear of crowds, fear of being alone, etc.

The theory of the interpersonal circle offers one possible rational correlation of these fears with docile-dependent operations. Fears, of course, tend to give the impression of weakness and helplessness. This pulls for help and support.

But the fears of the phobic are, in essence, displaced fears. It is well known that the relatively innocuous stimuli avoided by these patients generally stand for more directly intimate interpersonal figures who are covertly feared. We recall that Little Hans's panic about horses

was related to certain unconscious perceptions of his father and mother. (2) A repressive tendency is at work here. The patient cannot directly attribute hostile, dangerous motives to real, known figures but unconsciously displaces these motives to figures or stimuli which are vague, and psychologically distant. One effect of this is to allow the patient to preserve a consciously conforming, docile relationship with close figures against whom he may feel negative, rebellious emotions.

At this point the theory of the interpersonal circle can be introduced. The points *J* and *K* which define the phobic personality are midway between weakness (*HI*) and conventional agreeability (*LM*). On the circular diagnostic continuum, the phobic is related on the one hand to the obsessive and on the other to the hysteric. Clinically this suggests that phobics combine fears and obsessions on the one hand with a conventional, repressive, bland tendency to see family members and intimates as sweet and loving. The MMPI pattern for the phobic personality involves peak scores on depression, psychostenia, and hysteria. This tends to confirm the clinical impression of a person who is unhappy, anxious (D), worried, and fearful (Pt), and at the same time blandly repressive (Hy). He is afraid, but he does not know what he fears. He is helpless and weak within the context of docile, naïve conformity.

So far we have emphasized the phobic symptoms of the docile-dependent personality. The point has been made that inexplicable fears seem to fit nicely the mixture of weakness plus bland conventionality which characterizes this personality type. There are other symptoms which allow the patient to be helpless, depressed, and anxious, and to maintain a conforming conscious picture of self and others. Diffuse physical symptoms, for example, have the same psychological implications. They tend to be typical of, and partially diagnostic of, the docile phobic personality.

We are considering here symptoms which seem to be physical expressions of anxiety and tension; insomnia, transient digestive complaints (e.g., "butterflies in stomach" and nausea or bowel reactions in response to stress) and transient circulatory symptoms (blushing, fainting behavior, cardiac responses to stress, etc.). Many diffuse hypochondriacal concerns have docile-dependent overtones.

The interpersonal function of these symptoms is to present a picture of a worried, distressed person in need of help because of symptoms which have an indirect emotional significance. The patient suffering from diffuse physical symptoms often does not complain specifically or directly about his interpersonal problems or those of his intimates but displaces much of his concern onto areas which are

psychologically more distant and much more indirect. Again, he is anxious but he does not know why.

The third and most pathonomonic set of symptoms characteristic of the docile-dependent personality includes the manifestations of overt, free-floating anxiety. When a patient comes to the clinic openly expressing signs of weakness, discomfort, concern over self (e.g., tears, fidgeting, fearful behavior), then the security operations of phobic conformity may be suspected. The interpersonal message expressed by these tactics seems to be: "I am a distressed, weak, unhappy person in need of your help and direction." This and the preceding generalizations refer to the generalized or pure or consistent case. Many patients manifest alternations of behavior in a diagnostic interview. They may initially exhibit interpersonal reflexes of self-confident superior strength and then lapse suddenly into fearful, tearful behavior. In this case the hypothesis of intense phobic-counterphobic conflict would perhaps be considered.

Relationship of Docile Conformity to Standard Psychiatric Diagnosis

The preceding section has suggested that the interpersonal traits of overt docile dependence are related to certain clinical symptoms. These were anxiety, phobias, and diffuse physical symptoms.

Patients who employ these operations and manifest these symptoms can be given five different standard psychiatric diagnoses. The diagnostic label used is generally determined by the kind of symptoms which characterize the patient.

1. The term *anxiety neurosis* generally defines a docile-dependent personality. Malamud describes this diagnostic type as follows:

> Clinically, this disturbance expresses itself in attacks of vague, unexplained but intense fear which, at least in the beginning of the disease, does not seem to be attached to any particular object. It can best be described as being near to a normal fear of a vital danger, but is different from it in that no such danger is present and, in most cases, not even imagined to be present. The concomitant symptoms are usually of the same kind as found in real fear—a kind of paralyzed state of the musculature, cold shivers, a sense of pressure in the head and precordial regions, profuse cold sweating, palpitation of the heart, and at times relaxation of the sphincters. As time goes on the attacks may be consciously associated with some of the concomitant symptoms. The person may develop the fear that his heart may stop, that something will burst in his head, or that some serious disease is developing in his gastro-intestinal system. The concomitant symptoms may also assume the controlling feature of the picture, and thus instead of pure anxiety attacks we may have tachycardia, alternating constipation or diarrhea, dizziness, or even vertigo, and others. (3, p. 853)

The patient who complains of these symptoms usually approaches the clinician in a dependent manner, seeking relief and help.

2. The term *phobic* is also used to describe docile patients. Again the interpersonal implication of the fearful state is that the patient is a weak, helpless person. There is considerable overlap in the descriptions of anxiety neurotics and phobics. Notice in Malamud's definition the emphasis placed on fears. The difference between anxiety neurosis and phobia seems to involve superficial descriptive aspects of the content of what is feared. Both types seem to describe the same generic personality syndrome.

3. In the Freudian literature a similar overlapping of terms occurs. In defining *anxiety hysteria* Fenichel states that "the anxiety is specifically connected with a special situation, which represents the neurotic conflict. (1, p. 194) In discussing "the choice of the specific content" of the fears in anxiety hysteria, Fenichel (1, p. 195) moves immediately to a consideration of phobias, and it is clear that he considers phobias the characteristic symptom of the anxiety hysteric.

It appears that the terms *anxiety* and *phobic* as used in diagnostic labels are descriptive and symptomatic. The value of these terms for nosology is limited. One is led to question (1) the usefulness of descriptive diagnostic labels and (2) the proliferation of these overlapping terms.

4. There is a fourth standard diagnostic category which is related to the docile-dependent personality. This is the term *neurasthenic*. Malamud gives a description of this condition:

> In its pure form it is characterized by feelings of physical and mental inadequacy, complaints of fatigability without adequate exertion, paresthesias in the back of the neck, and a sense of general weakness. In the more chronic and severe forms of this disturbance the patients usually describe themselves as mental and physical "wrecks." They cannot concentrate on any activity, they wake up in the morning feeling exhausted, "fagged out," unable to get started on any work. Irritability, feeling of lack of sexual vigor at times amounting to impotence, and a vague sense of anxiety may complicate the picture. In contradistinction to the anxiety neuroses, these states are usually monotonously chronic without any great degree of variation and as is too frequently the case the patient seeks for help only after long duration of the symptoms. (3, p. 854)

The similarity of neurasthenia to anxiety neurosis is apparent in this description and is, in fact, recognized by Malamud. It seems that the differentiating factor is chronicity—a dubious reason for retaining a nosological category.

5. A fifth diagnostic term which usually defines the overtly dependent personality is *hypochondriasis*. Diffuse physical symptoms and worry about bodily functions can serve as a defense in many types of maladjustment. Often these concerns operate in very sick patients to ward off psychotic processes. It is safe to say that in any hypochondriacal condition, whatever the underlying problem, displace-

ment and repressive processes are at work. At the level of presentation to the clinic the interpersonal implications of hypochondriasis are (1) dependence and need for help and (2) some tendency to displace negative emotions onto physical reactions. These two factors are characteristic of the personality type we are discussing in this chapter.

Research Findings Characteristic of the "66" Personality

This section presents a summary of some of the empirical studies accomplished on the phobic personality at the Kaiser Foundation research.

1. Patients who present docile conformity in their overt operations do not tend to have the psychosomatic symptoms of ulcer, hypertension, or neurodermatitis. (Although they do not manifest organ neuroses, they do tend to complain of diffuse physical symptoms of anxiety.)

2. Docile dependency at Levels I and II is related to depression (D), ruminative worries (Pt), and naïve blandness (Hy) on the MMPI.

3. These patients tend to be initially well motivated for treatment, remaining in treatment for an average of eleven interviews. Pure phobics (i.e., without underlying ambivalence) remain in treatment an average of twenty times, that is, longer than any other diagnostic group. They are solidly docile and dependent. Conflicted phobics (i.e., with underlying hostility, strength, or conventionality) on the contrary do not remain in treatment, being seen on the average of 2.6 sessions. This dramatic reversal of the pure and the more ambivalent cases points up the necessity of fitting the variability dimension into the diagnostic picture.

4. Docile subjects are on the average ambivalent in their conscious identification with parents. They are not so disidentified as the psychopaths, schizoids, and obsessives. They are less close to their parents than the conventional and responsible personality types.

5. They are similarly about in the middle on the variable of marital identification, being closer to their marital partners than the unconventional diagnostic groups and less close than the conventional.

6. Docile patients consciously describe their parents as being conventional, agreeable, and somewhat nurturant people. This reflects a conforming attitude to parents and places them close to the hysterical and psychosomatic patients. Phobics picture themselves as weaker than the latter two personality types, but share their conventional perception of parents.

7. Phobics emphasize nurturance in their conscious description of marital partners more than any other diagnostic group. They are

themselves dependent and marry people whom they see as strong and giving.

8. They are therefore not identified with their spouses but report reciprocal "needs help–gives help" marital relationships.

9. On the Naboisek study of interpersonal misperception, phobics (when combined with obsessives) seem to be the most accurate of any diagnostic type. They correctly perceive the strong to be strong and the weak to be weak. They manifest misperception only in the case of the hostile persons, to whom they erroneously attribute more weakness than hostility. Docile dependent patients seem to be thrown off by aggressiveness in others, preferring to see this as weakness. This may reflect an avoidance of the same interpersonal themes they avoid in their overt behavior.

10. The phobic personality is found most frequently in certain institutional and cultural settings. Docile people (Level I-M) *do* come to the psychiatric clinic for help. They are not found as frequently in normal nonclinical settings (see Table 20).

TABLE 20

PERCENTAGE OF DOCILE-DEPENDENT PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Docile-Dependent Personalities*
Psychiatric Clinic Admissions	537	12
College Undergraduates	415	2
University Psychiatric Clinic	133	10
Middle Class Obese Patients (Female)	121	5
Overtly Neurotic Dermatitis Patients	31	10
Self-Inflicted Dermatitis Patients	57	5
Unanxious Dermatitis Patients	71	3
Group Psychotherapy Patients	109	11
Individual Psychotherapy Patients	49	16
Hypertensive Patients	49	5
Ulcer Patients	43	5
Medical Control Patients	37	5
University Counseling Center (Male)	93	2
University Graduate Students (Male)	39	5
Stockade Prisoners (Male)	52	6
Hospitalized Psychotic Patients	28	21
Officers in Military Service	39	0
Total	1903	

11. Docile-dependent patients tend to be assigned to individual psychotherapy. They are second only to the obsessives in the per cent referred to and remaining in individual treatment. They are not referred as frequently to group therapy. They do not remain in group

psychotherapy as frequently. Four other diagnostic types supply more patients who remain in groups. The phobics top only the hysterics, psychopaths, and narcissists in percentage of group therapy numbers. This is probably due to the following facts: The phobic tends to be quite ambivalent about treatment in general. He wants help but not necessarily psychological exploration. When he is seen individually, this ambivalence about motivation and commitment to therapy can be made the focus of attention and dealt with directly. The docile patient is more likely to feel comfortable in a two-way doctor-patient relationship. The dependent operations work more smoothly. In a group the ambivalent motivation is very easy to overlook. The patient does not have a single comfortable situation of a nurturant therapist but is thrown into interaction with several other patients and personality types. Underlying ambivalences can be intensified and the phobic often drops out of the group.

12. The frequency of docile-dependent subjects at Level II-C is presented in Table 21. It will be noted that this personality type is again most numerous among hospitalized psychotics. The second most frequent occurrence of this personality type is in the individual therapy sample.

TABLE 21

PERCENTAGE OF DOCILE-DEPENDENT PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Docile-Dependent Personalities*
Psychiatric Clinic Admissions	207	11
Hospitalized Psychotic Patients (Male)	46	20
Group Psychotherapy Patients	101	11
Individual Psychotherapy Patients	38	18
Overtly Neurotic Dermatitis Patients	31	3
Self-Inflicted Dermatitis Patients	56	13
Unanxious Dermatitis Patients	70	3
Medical Control Patients	41	5
Ulcer Patients	42	2
Hypertensive Patients	49	6
Middle Class Obese Patients (Female)	100	2
Total	781	

Therapeutic Handling of the Phobic Personality

Some phobics express underlying counterphobic power; others show sweet hysterical conventionality in their "preconscious" expressions. Entirely different therapeutic results may be expected from these varied multilevel patterns even though they are all presented overtly in the same way. Generalizations about the phobic personality

must therefore be considerably limited, although it is possible to examine some of the implications of the docile façade which seems to characterize most phobic patients.

The first characteristic worth noting is their apparent readiness and eagerness for psychiatric *help*. The word help is used here in contrast to the word treatment—for many phobics are not at all eager for extended therapy. Because of their dependence, their admission of fear and weakness, they give the appearance of being highly motivated and cooperative patients. This appearance is often misleading.

Phobic patients in their underlying levels have their share of all the sixteen generic interpersonal motivations. They have as much (or perhaps more) ambivalence and conflict as any other overt personality type. The deceptive factor here is the fact that they have a façade of cooperative, passive docility. This often lulls the imperceptive clinician into the expectation that the patient is wholeheartedly involved in the treatment plan. If questioned, the phobic may appear to be in complete conformity with the program outlined by the clinician. Here we think of the typical and familiar phrase, "I'll do anything you suggest, Doctor."

Thus the ambivalence and conflicting motivation which we expect in almost every patient tends to be easily overlooked in the case of the docile phobic.

In dealing with most other overt personality types, the intake diagnostician is automatically led to look for ambivalence or conflict. In the case of the schizoid patient some partial abandonment of his distrustful operations is required in order for him to express the collaborative feelings involved in a commitment to therapy. Similarly, a strong, self-confident counterphobic patient must make some admission of weakness and need-for-help if he is to commit himself to treatment. In the case of the docile phobic patient, ambivalence is often present but can be easily overlooked because of the superficial eagerness of these patients to please and conform to the clinician's suggestions. For this reason these patients tend to present tricky and confusing prognostic problems. In the early days of the clinical training program at the Kaiser Foundation clinic, phobic patients were often assigned for therapy to novitiate interns. The reasoning was: "These patients are anxious, cooperative, well-motivated, and not too distrustful, and are thus excellent patients for the beginning therapist."

This generalization has proved optimistic. We have found it to be difficult to predict the clinical course of an overtly docile patient.

In a preceding section it has been pointed out that phobics on the diagnostic continuum fall between hysterics and obsessives. Functionally, this means that they tend to combine punitive self-deprecia-

tion and bland naïveté. The repressive hysterical element often leads phobics to an early departure from the clinic as soon as they sense that therapy is not a magical cure but rather a process of realistic self-evaluation. The latter, of course, is quite alien to the repressive operations.

We have found that many phobics can present an initial façade which involves severe anxiety, marked conformity to treatment plans, and apparent motivation for therapy. The underlying motivation may involve other interpersonal operations and might predict an early "repressing" out of therapy, or the development of severe feelings of distrust and isolation, etc. Phobics may often resist (in a conciliatory manner) the clinician's attempt to clarify their motivation—particularly if they sense that a reproach or criticism is implied. This is generally followed by a reaffirmation of their willingness to conform to the "doctor's orders." A supportive and sympathetic explanation of the phobic's motivation will often allow the patient to express his underlying doubts, or fears, or critical resistance to psychotherapy.

Again it must be recalled that these comments are limited by the multilevel variations which differentiate the 2,048 types who present overtly as docile-dependent. The temporal sequence of interpersonal behavior to be expected varies according to the configuration of the total personality. The therapeutic handling of overt phobics, therefore, varies according to these differences.

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18

Adjustment Through Cooperation: The Overconventional Personality

Conventional, friendly affiliation with others is the mode of adjustment discussed in this chapter. This is the "77" personality type. We shall be discussing those individuals whose overt security operations involve agreeability, and who strive to be liked and accepted by others.

Adaptive Forms of the Conventional Personality

Extroverted friendliness is the adaptive form of this generic security operation. The individuals who utilize these interpersonal reflexes seem to be comfortable when they are evoking "good feelings" and establishing harmonious, amicable relations with others.

They tend to seek satisfaction in sociability with others. Accepted values are important to them. They are more likely to cooperate, to go along with the conventional pattern, to compromise. External harmony is more important than internal values. They are less likely to emphasize a unique, original, or highly controversial point of view.

Individuals who employ this interpersonal machinery with flexibility are productive and valuable members of society. They are popular, well-liked, and agreeable members of any group. They deal with social anxiety by friendly, amicable responses.

This mode of adjustment is probably the highest stated ideal of our Western civilization. The loving, peaceable, brotherly person is given the most honored role in the ethical hierarchy. This is, it must be noted, a cultural ideal. The personal ideal of most individuals (as measured by the interpersonal system) clearly emphasizes a combination of conventionality and strength. The pure loving person is the third most idealized figure, power and sympathetic responsibility being the ego-ideal values preferred by the individuals studied. The person who acts or describes himself in terms of cooperativeness and

friendliness seems to be attempting to meet the stated rather than the real cultural conventional standard.

Maladaptive Forms of the Conventional Personality

Individuals who rigidly and inappropriately express agreeable, affiliative behavior are diagnosed as overconventional personalities. These are the persons who cannot tolerate any critical or strong or guilty behavior in themselves. They continually strive to please, to be accepted, to establish positive relations with others.

It is difficult to describe these security operations because the English language has a scarcity of words denoting this condition. It was pointed out in Chapter 2 that our English dictionaries do not contain terms defining the state of being overaffectionate or too friendly or overcooperative. The notion that a person can be maladaptively sweet is apparently alien to our culture.

Thus we face the dilemma of describing persons for whom there exists no ready-made, common terminology. We have had to meet this problem (in our empirical studies) by hyphenated words or extended phrases denoting the person who is abnormally and rigidly friendly.

The items on the interpersonal check list which designate this condition are:

L	*M*
too easily influenced by friends	fond of everyone
will confide in anyone	likes everyone
wants everyone's love	too friendly
agrees with everyone	loves everyone

The interpersonal behaviors which diagnose these security operations involve the compulsive, repetitious expression of affiliative behavior. These individuals smile, agree, collaborate, conciliate. They are extroverted and outgoing to an intense degree. They are so committed to conventional responses that they forfeit originality and individuality.

External values and approval from others dominate their social intercourse. Bland, often naïve, uninsightful behavior is the inevitable correlate. Gross misperceptions of social reality characterize their approach. They just cannot see hostility or power in themselves. They avoid feelings of depression. A rigid overoptimism is quite typical. They often misperceive the interpersonal behavior of others and tend to saturate all their social exchanges with affiliative motifs.

The maladaptive aspects of these security operations are obvious. Like any set of crippled reflexes, the repetitious and inappropriate ex-

pression of positive feelings lends to a general restriction of personality. Their repertoire of responses is narrow. They are limited only to the conventional actions and perceptions. They forget or misinterpret other kinds of behavior. They seem to fear being individuals. Their imagination and creativity is lost in the attempt to be acceptable or to be liked. A sterile conventionality or a self-satisfied piousness results.

The Purpose of Overconventional Behavior

The security operations of conventional agreeability are employed to ward off anxiety. These individuals are uncomfortable in the presence of hostile, unhappy, or power-oriented feelings. They avoid these responses.

The overconventional person apparently has learned that he can reduce anxiety and gain heightened self-esteem by means of optimistic blandness. He has discovered that acceptance and approval from others can be won by means of friendly operations. He feels safe, comfortable, secure when he is employing these protections.

When the reality situation involves unconventional behavior or threatens their optimistic (and often shallow) approach, these subjects become upset. They may strive to handle the situation by increased optimism and sociability. If these maneuvers fail, they tend to get out of the anxiety-provoking field. Psychiatric evaluation and self-exploration are, of course, among the most threatening events faced by this personality type.

Their unique methods for handling the anxiety aroused by psychiatric referral will be discussed below.

The Effect of Overconventional Behavior

Friendly agreeability tends to provoke approval and friendliness from others. In the systematic language, *LM* pulls *MN* from others. The extroverted, optimistic person trains others to like him. Cooperativeness induces a reciprocal positive response in others.

These reciprocal relations are, of course, part of the folklore of our culture. The Dale Carnegie texts and the salesmen's manuals have pointed out the effect of the "positive approach," and our empirical studies have tended to confirm these bromides.

A qualifying remark must accompany these generalizations. The principle of reciprocal interpersonal relations is a probability statement. It tends to hold most of the time. There are many cases where it does not work. *LM* does not *always* pull *MN*.

The maladaptive intensity of the response provides a special case. Many situations call for anger or sorrow or power. If the overcon-

ventional person is unable to respond appropriately, his attempts to win approval may fail.

The personality of the "other one" is another important factor. If the *alter* in any social interaction tends to respond with a different interpersonal reflex, then the ability of the overconventional person to pull approval is limited. Skeptical individuals can be infuriated by overoptimism in another. Power-oriented individuals may see cooperative agreeability as a form of docility and an invitation for them to increase their bossy reflexes.

The selectivity of interpersonal relationships enters the picture at this point. Overconventional people tend to avoid persons and places which threaten their façades. The "sicker" or more restricted the person is, the less able he is to tolerate differences which raise anxiety. Thus it often transpires that bland overfriendly persons tend to gravitate towards other agreeable, optimistic, pious, conventional people and do not tend to seek out antisocial or highly original partners.

In cases where negative feelings are involved, these patients characteristically resolve the situation by the maneuver of "going along" with the feelings of their in-group. If the group to which they conform is angry, they can be angry; but the hostility is directed against an out-group figure and it is usually not expressed directly. These subjects can be very critical of an out-group person who is not present.

The generalizations made in this section require qualification. Multilevel variations and conflicts provide new complications. Some patients with overconventional façades tend to have underlying feelings which involve less-conventional themes (such as masochism or sadism). These "preconscious" tendencies may lead them to become involved with individuals who are unloving and unconventional.

Even with the qualifications introduced by multilevel conflicts and by the personality of the "other one" the general principle of reciprocity holds as a low-order probability statement. Patients with low scores on nonconformity (i.e., the F scale on the MMPI) see themselves as loving and cooperative and are seen in the same positive fashion by fellow group therapy members.

Clinical Manifestations of the "77" Personality

There are several clinical characteristics of the overconventional personality.

First it should be noted that this personality type is not a common visitor to the psychiatric clinic. The essence of the psychiatric process is self-examination and an analysis of one's own unique patterns of living. The essence of the bland, friendly overagreeable mode of

adjustment is the inhibition of one's uniqueness and one's individual feelings and the emphasis on external values.

The overconventional person does not come to the psychiatric clinic because of a dissatisfaction with self or a desire for self-examination. He is not depressed. He does not complain of internalized emotional problems (e.g., guilt, distrust).

The specific symptomatic picture can vary, but the interpersonal message of bland self-acceptance is usually present.

There are three reasons which bring these patients to a psychiatric clinic. These are (1) generalized "nervousness" or anxiety, vaguely defined and not tied to emotional causes; (2) physical symptoms, often with a direct symbolic meaning; (3) complaints about the behavior of others.

The first of these complaints—generalized nonspecific anxiety—is the most common symptom, so typical that it is quite diagnostic. These patients use the words *tension*, *nervousness*, and *anxiety* in their self-descriptions. The significance of these particular terms is that they have a relatively vague quality. They designate a symptom which is not tied to a specific, recognized emotional problem. The patient does not know why he is anxious. He is not depressed or fearful. This differentiates the overconventional from the phobic personality. The latter is unhappy and sees himself as weak and timid. The overconventional person comes to the clinic because of anxiety which is described as a phenomenon quite removed from his personality.

This symptom of vague tension can generally be traced to an interpersonal trauma or friction in the patient's life. Pressure is being put on the patient to react in a negative way (hostile or defeated). The overconventional person cannot handle these situations appropriately. He strives not to recognize the emotions which they arouse in him. His rigid attempts to misperceive and deny negative feelings in himself and others seal off the emotional meaning and leave him only with intense anxiety. The threat of his own negative feelings (usually provoked by the traumatic external pressure) is the most intolerable experience for this personality type. He comes to the clinic, needless to say, not consciously desiring to have the cover removed from his misperceptions and negative emotions but to have the anxiety removed. When these patients sense that psychotherapy might threaten their bland denial they clearly express their disinterest in treatment.

These patients present particularly pathetic pictures when they arrive at the psychiatric clinic. Their fear of their own negative feeling brings on the tension, but psychiatric interviews tend to arouse exactly the same anxiety. Caught between the pain of the illness and

the pain of the cure, they usually handle this dilemma by intensification of their favored security operations; that is to say, they attempt to re-establish their bland, optimistic protections and move themselves out of the therapeutic situation.

The complaint of diffuse tension can thus be seen as a symptom external to the patient's view of his own character structure. They come to the clinic seeking relief from this isolated symptom and not psychological explanation. This extended discussion of one symptomatic presentation has been outlined in detail for two reasons. First, it is important for the clinician to recognize the fact that the complaint of tension or nervousness is not attached to the patient's conception of himself as a person. The intensity of the anxiety may make these patients appear to be well motivated for therapy. The bland, conventional nature of their security can be revealed by sensitive interviewing and is picked up very clearly in the Level I and Level II tests. Failure to distinguish this difference may lead to a breakdown in communication and the patient's flight from the clinic. The second important aspect of this syndrome is its frequency. Over 50 per cent of the overconventional patients seen in the Kaiser Foundation mention the vague, nonspecific terms *tension*, *nervousness*, or *anxiety* in describing their reasons for coming to the clinic.

The second most frequent symptom mentioned by "77" patients involves physical complaints. These are often symbolic of unrecognized emotional conflicts. Headaches (which our clinicians believe to reflect underlying hostility) and menstrual complaints (believed to reflect sexual constriction) are probably the most common physical symptoms. Examination of the case material of overconventional patients reveals that the great majority of the female patients are sexually frigid. This is sometimes recognized but is rarely developed as a complaint, these patients being unalarmed about this condition. The physical symptoms classically characteristic of hysterical blandness (e.g., paralyses, amnesias, anaesthesias) are rarely seen in the Kaiser Foundation clinic. When they do appear they are not generally reported by the pure overconventional personality (77) but by severely or chronically disturbed patients with conflicted façades. We think here of the schizoid-hysteric (47) or the masochistic-overconventional conflict (57).

The third clinical characteristic of the "77" personality involves complaints about the behavior of other people. A sudden flare-up of marital trouble (previously unrecognized) is a common precipitating event. The spouse may demand a divorce, thus breaking through the optimistic façade and confronting the "surprised" patient with unpleasant emotions. Antisocial behavior on the part of a family mem-

ber (delinquency, crime, sexual eccentricity) may bring about the same result.

These situations confront the patient with emotions which his security operations have previously denied. It must be noted, however, that the resulting anxiety is not seen as intrinsic or related to the personality but (like the diffuse tension or physical symptom) is seen as external.

Turning from the symptomatic picture to the clinical impression given by these patients, we see a new set of diagnostic cues.

The bland overconventional person is often seen as *immature* by the clinician. This term runs through the typical case reports and reflects the naïveté, the artless, childlike ingenuousness which these security operations maintain. These patients see no evil, hear no evil, think no evil, do no evil. They handle interpersonal situations by complaisant, serene machinery.

The rigidity by means of which these individuals can distort and misinterpret reality can reach astounding proportions. These misperceptions (sincere and not deliberate) can lead to disastrous misunderstandings. We think here of the patient who employed two solid layers of bland optimistic friendliness to handle feelings of despair so severe as to reach psychotic proportions. In the face of several catastrophic failures (loss of two jobs, threatened divorce), this patient insisted in the intake interview that everything was going well, that he was not depressed, etc.

The discrepancy between the reality situation and his happy reactions finally emerged. The intake worker reviewed with the patient the intense conflict between desperate fearful depression and the cheerful façade. The latter operations were supported, but the need for treatment was stressed. The patient was delighted with the course of the interview, enthusiastically accepted the mild summary of the clinician, and eagerly cooperated in making plans for therapy, arranging future appointments, etc.

Within two days the clinician received phone calls from three irate and puzzled people (his wife, his employer, and the referring physician), all of whom had been informed by the patient that "the psychiatrist said I am perfectly normal and don't need treatment." In a subsequent interview the patient remembered the negative or reality side of the clinician's original summary and stated that he had "forgotten" the plans for therapy and discovered the appointment slip which had been "lost" in his wallet.

This patient was not a dishonest or prevaricating person. The rigidity and intensity of the ingenuous naïveté, as well as the complete crippling of any other interpersonal reflexes, were quite evident

in his Level I and II test patterns and testified eloquently to the presence of a blanket denial process which made it intolerable for this person to face unpleasant reality.

This same process is regularly observed in group therapy where hysterical patients completely misperceive hostility in others and forget the occasion when they have been momentarily angry or depressed in the group.

The Relationship of Overconventionality to Standard Psychiatric Diagnosis

Patients who manifest the reflexes of intense, maladaptive overconventionality are often given the psychiatric diagnosis of *hysterics*.

If we review the clinical characteristics of the conventional personality, we will observe that they tend to fit the general conception of hysterical behavior—the physical symptoms, bland denial of emotional problems, etc.

The chapters in psychiatric texts which describe the hysteric usually center the discussion around the dramatic symptomology: fugues, amnesias, paralyses, etc. (3, 2) In recent years these colorful symptoms tend to appear in diminishing frequency and the diagnosis of hysteria is increasingly being based on dynamic, interpersonal or psychosexual criteria (4, 1).

The bland, optimistic conventionality of the hysteric has been discussed in the literature for over sixty years. Charcot defined this diagnostic characteristic in describing "la belle indifférence des hysteriques."

The current trend in diagnosis seems to emphasize the dynamic aspects of the hysterical personality. Schafer in his competent diagnostic volume (4) consistently employs "functional" or dynamic variables rather than symptomatic or descriptive cues. He defines hysterics as persons who "rigidly and persuasively resort to the defense of repression." He speaks of the narrowed cultural and intellectual interests, the impaired ability to think independently or to express original, individual themes. He also refers to the naïveté of these patients.

In the interpersonal diagnostic system the term hysterical personality is used to describe patients whose presenting operations stress bland, narrow conventionality. It must be emphasized that we are diagnosing overt operations. Hysterics vary considerably in their underlying motivation. Some patients employ an optimistic overcooperative façade to mask underlying schizoid or sadistic feelings. Other overt hysterics present solid, four-layer structures of friendly congeniality.

When we employ the term *hysteric*, we do not necessarily designate the "simple-hysteric-serving-girl" syndrome for which suggestion and hypnosis have traditionally been used as therapeutic tools. Patients with overt hysterical operations can be very complex in their multilevel patterns. A wide variety of treatment regimes can be recommended depending on the nature of the underlying material, the ability to tolerate the warded-off emotions, etc.

Research Findings Characteristic of the "77" Personality

Here is a summary of the empirical studies of the overconventional personality.

1. Patients who utilize overconventional security operations present MMPI profiles which stress hysteria (Hy) and denial-of-psychopathology (K) and which underemphasize schizoid isolation (Sc) and nonconformity (F).

2. These patients are not well motivated for psychotherapy. They remain in treatment for an average of nine sessions and rank fifth among the eight diagnostic types on this variable.

3. They are closely identified (consciously) with their mothers and their marital partners—ranking third among the eight diagnostic types on this variable.

4. They are the most consciously identified with their fathers of any diagnostic group.

5. They misperceive the behavior of others by attributing too much friendliness and affiliativeness to others. They tend to blanket others (in their therapy groups) with the same conventional sweetness that they claim for themselves.

6. The overconventional personality appears in certain cultural and institutional samples more frequently than others. The percentage of hysterics in various samples at Level I-M is presented in Table 22.

The highest percentage of overconventional cases is presented by the self-inflicted dermatitis group. These patients bend over backwards to inhibit the unconventional at Level I, although in their fantasies they are more hostile than any other sample (see Chapter 24).

Another high percentage of hysterical subjects is found in the hypertensive example. This is an expected result. It has been repeatedly claimed in the psychosomatic literature that hypertensives present unusually sweet friendly façades. This bit of clinical folklore has been confirmed by the Kaiser Foundation research studies on psychosomatic subjects, in which we have found hypertensives presenting the façades of conventionality.

An equally high percentage of hysterical subjects is found in the individual therapy sample. We have already noted that they do not

TABLE 22

PERCENTAGE OF COOPERATIVE-OVERCONVENTIONAL PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Cooperative-Overconventional Personalities*
Psychiatric Clinic Admissions	537	9
College Undergraduates	415	3
University Psychiatric Clinic	133	8
Middle Class Obese Patients (Female)	121	10
Overtly Neurotic Dermatitis Patients	31	6
Self-Inflicted Dermatitis Patients	57	14
Unanxious Dermatitis Patients	71	11
Group Psychotherapy Patients	109	6
Individual Psychotherapy Patients	49	12
Hypertensive Patients	49	12
Ulcer Patients	43	10
Medical Control Patients	37	5
University Counseling Center	93	8
University Graduate Students (Male)	39	0
Stockade Prisoners (Male)	52	10
Hospitalized Psychotic Patients	28	4
Officers in Military Service	39	3
Total	1903	

tend to remain long in treatment. The identity of the groups with the next highest frequency of hysterical personalities is, however, somewhat startling. The ulcer sample, the obesity sample, and the stockade prisoner sample are tied for third rank. This suggests that the most conventional sample (middle class women seen in a nonpsychiatric setting) and the most antisocial sample (prisoners) share the same percentage of naïve, bland subjects!

From the standpoint of a multilevel theory, the latter result is not completely unexpected. Many of the most severely antisocial individuals present façades of piety and virtue which are almost painful to observe. Many delinquents, addicts, criminals are characterized by a bland, naïve, innocent front behind which rage intense feelings of distrust or rebellion.

The same is true of some institutionalized psychotics. This fact has confused some psychologists who observed that some of the most severely disturbed paranoids and deluded schizophrenics presented hysterical, repressive MMPI profiles. Some state-hospital psychologists have reported that the MMPI is invalid because so many psychotic patients have conventional, bland records. This objection completely misses the multilevel complexity of personality. Many hospitalized patients are psychotic because they tried to maintain a brittle façade of pious, self-satisfied virtue and were unable to tolerate their own intense

hostile or guilty feelings. Many psychotics and delinquents attempt to preserve the appearance of naïve innocence and are diagnosed (by the interpersonal system) as hysterics or hypernormals (at Levels I and II) with underlying feelings of a more antisocial nature.

7. The frequency of this personality type at Level II-C is slightly different from the picture at Level I-M (see Table 23). The sample of normal controls (labeled medical controls) manifests the largest percentage of overconventional personalities. Individual therapy patients again provide a larger percentage of this type. The psychosomatic and neurotic samples run about equal to chance expectancy except for the ulcer group. The self-diagnosis of this latter symptomatic sample seems to emphasize stronger and more competitive feelings (see Chapter 24).

TABLE 23

PERCENTAGE OF COOPERATIVE-OVERCONVENTIONAL PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Cooperative-Overconventional Personalities*
Psychiatric Clinic Admissions	207	15
Hospitalized Psychotic Patients (Male)	46	9
Group Psychotherapy Patients	101	10
Individual Psychotherapy Patients	38	18
Overtly Neurotic Dermatitis Patients	31	19
Self-Inflicted Dermatitis Patients	56	14
Unanxious Dermatitis Patients	70	20
Medical Control Patients	41	22
Ulcer Patients	42	2
Hypertensive Patients	49	12
Middle Class Obese Patients (Female)	100	11
Total	781	

8. Hysteric patients consciously perceive their parents to be sweet and docile. They describe their fathers as being conventional and loving (ranked third out of the eight diagnostic groups on the LM axis). They see their mothers as being sweet, docile, and trustful (ranked second on the affiliative axis and third on the passivity axis).

9. These patients, on the contrary, see their spouses as relatively hostile (ranked fifth on the affiliative axis). They describe their marital partners as more hostile than do the schizoid and narcissistic patients. This seems to fit in with the clinical finding that these patients come to the clinic not because of dissatisfaction with their own character structure or with their past life (e.g., their parents) but because of current external stress (which often involves misbehavior of or rejection by their spouses). The hysterics thus "cross the circle,"

attributing themes to their marital partners which are the opposite of their own self-conceived sweetness. Narcissistic patients, it might be noted, do the opposite. They present themselves as superior, snobbish, competitive, and somewhat exploitive. They picture their spouses as being the most naïve, docile, and gullible.

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19

Adjustment Through Responsibility: The Hypernormal Personality

In this chapter we shall become acquainted with the responsible hypernormal personality type. This comprises those patients whose overt behavior locates in the *ON* octant of the diagnostic grid. This is the "88" personality type. These individuals employ strong and conventional security operations. They present themselves as reasonable, successful, sympathetic, mature. They avoid the appearance of weakness or unconventionality.

Adaptive Forms of the Responsible Personality Type

Here we deal with the individual who attempts to present himself as a "normal" person. He presents himself as strong—but his power and self-confident independence are used in an affiliative way. He strives to be close to others—to help, counsel, support, and sympathize. He wants to be seen as tender with his intimates, reasonable and responsible with his acquaintances.

These individuals often give the impression of maturity and parental strength. They appear sound, sympathetic, considerate. They are often popular figures—they attempt to get along well with others and to provoke admiration from others. They are leaned upon and depended upon by other people. They strive to fulfill an idealized role of successful conventionality.

Maladaptive Forms of the Hypernormal Personality

An inflexible, repetitious use of responsible, hypernormal reflexes leads to a maladaptive condition. Individuals of this type cannot take a passive or aggressive or bitter role, even when it is called for. They avoid these latter behaviors so compulsively that they become caricatures of hypernormality.

These individuals "knock themselves out" to be popular. Their attempts to be helpful and responsible are often inappropriate. They may overextend themselves in promises to others—offers of help and sympathy which they cannot fulfill. They may desperately attempt to maintain the façade of normality when the situation and their own private feelings involve other reactions. They are often driven by relentless ideals of service and contribution to others.

Extreme *NO* behavior inevitably leads to a bland, uninsightful façade. These individuals cannot tolerate unconventional or weak feelings. They are so compulsively attached to their hypernormal strivings that they completely deny and inhibit feelings of frustration and passivity.

These extreme operations generally indicate severe conflicts which are expressed not in the classic symptoms of neurosis, but in indirect (often psychosomatic) manifestations.

The Purpose of Responsible or Hypernormal Behavior

Those human beings who are strong and conventionally normal have selected these operations because they find them most effective in warding off anxiety. Their feelings of self-esteem are bolstered by appearing mature and generous. They are most secure when they are involved in close, friendly protective relationship with dependent others.

They are, we assume, most threatened by the prospect of appearing defeated, deprived, unfriendly, or passive. Their genial, generous operations tend to relieve feelings of anger, helplessness, or isolation. They give the assurance (at least consciously) of being involved in tender, protective relations with others.

There are many obvious rewards to the responsible hypernormal way of life. This mode of adjustment is close to the cultural ideal. It thus brings great conscious superego satisfactions. These patients are the most self-satisfied individuals seen in the clinic.

In its adaptive form this is a most positive and socially constructive personality type. In that utopian society where skepticism, sternness, competition, or modesty would not be necessary responses and where consistent affiliative behavior would be appropriate, the generous *NO* type would be the rule. Even in the nonutopian twentieth century culture the ideals of tender, protective nurturance are undoubtedly the most appealing standards. The conventionally successful and popular person in our society is usually the one who employs the *NO* interpersonal reflexes a large part of the time.

Compulsive and inappropriate maintenance of these operations leads to the phenomenon of the "hollow man"—isolated by his self-

satisfied piety from the realities of life and (more dangerously) from his own inner feelings of bitterness or weakness.

The Effect of "88" Behavior

Responsible, protective behavior pulls dependence and respect from others. The person who overtly gives tends to attract those who want to receive. In the language of the interpersonal system, *NO* pulls *KL*.

Tender, supportive operations tend to train others to agree, conciliate, and depend. This rule (like the previous generalizations about interpersonal reciprocity) is a probability statement. Generosity does not always pull friendly dependence. Those who are rigidly committed to other interpersonal reflexes will react to the reasonable, generous person with their favored responses. In general, however, most people tend to expect good things from those who promise good things.

Another exception to this rule of reciprocity (i.e., *NO* pulls *KL*) occurs when the hypernormal behavior is extreme or inappropriate. Here we think of the overmotherly woman, the compulsive popularity seeker, the overprotective parent. While these behaviors generally tend to pull cooperative dependence, their uncalled-for intensity may eventually provoke resentment or frustration from the "other one."

In therapy groups, the "88" individual takes the role of the assistant therapist. He encourages, suggests, and sympathizes with the other patients. He does not exhibit needy or helpless reflexes but is seen as the competent helpful leader.

Typically the group members cannot understand why he is in therapy. They see his reasonable, generous façade as an ideal adjustment. At this point the interpersonal network tightens. The other patients increasingly put more dependent pressure on the "88" person. He is now being asked for help, expected to give, and is given less and less allowance to present his own problems as a fellow patient.

These patients are thus the popularity leaders of the group. By acting in a hypernormal way they are not seen as patients needing help. They build up an interpersonal process which would lead to their getting no therapeutic help from group therapy. At this juncture the task of the therapist is to step in and assist the "88" person in understanding what he has done to the others to block himself off from the possibility of help.

Clinical Manifestations of the Hypernormal Personality Type

Patients whose overt security operations strive towards normality do not present the typical neurotic symptoms when they appear in

the psychiatric clinic. They are not anxious or depressed. They do not report interpersonal failures. They do not complain of timidity, isolation, distrust, etc. They tend to describe their emotional adjustment as adequate and normal.

Why then, do they come to the clinic? In the Kaiser Foundation clinic which services a large general hospital, 23 per cent of all applications are hypernormal individuals. The overwhelming majority of these patients are not self-referred, but have come at the request of a physician. Their symptoms are psychosomatic or physical.

From 40 to 50 per cent of patients with psychosomatic diseases fall in the *NO* octant. (The frequency expected by chance is 12.5 per cent.) Seventy-nine per cent of psychosomatic patients fall in the *NO* octant or its two neighboring octants. For this reason patients who locate in this sector of the diagnostic grid can be called psychosomatic-type personalities.

It must be pointed out that we refer here to *organ neurosis* conditions and not to somatic expressions of anxiety (nervous stomach, transient pains, etc.). The latter are typical of the docile phobic personality. The symptoms manifested by the "88" personality are not transitory expressions of tension. The hypernormal personality is usually successful in warding off anxiety and presents a bland, strong façade.

In addition to psychosomatic symptoms the "88" personality often comes to the clinic for the purpose of putting indirect pressure on family members. They may present a story of marital difficulty in which it becomes clear that the spouse or a child is "sick and in need of help." The subject may recount a history of patient tolerance of the family member—the implication being that the diagnostician will give the patient a clean bill of health and suggest that the errant spouse be brought in to treatment. The poised, "mature" reasonableness of the "88" façade may tempt the inexperienced clinician into collaborating in the plans to inveigle family members into therapy.

A third reason for the "88" personality coming to the clinic involves certain forms of isolated behavior disorders such as alcoholism, gambling, or certain sexual aberrations. These patients may be self-referred or sent in by family pressure or court order. They readily see the symptomatic behavior as ego-alien—but isolate it from their personality. The motto for these patients might be: "I am a well-adjusted nice guy—if only I could get rid of that crazy behavior pattern."

Many alcoholics or addicts fall into other diagnostic categories. The guilty or the defiant types do not, of course, locate in the "88" sector of the diagnostic grid. Many behavior-disorder patients, however, do attempt to maintain a repressive hypernormal façade.

Many cases of impotency or frigidity fall in the hypernormal sector. Here again the symptom (like that of the psychosomatic) is seen as isolated from the well-adjusted personality.

Many severely deluded paranoid patients present themselves as hypernormal at the symptomatic level. This is really not a paradoxical situation if the theory of levels is kept in mind.

Level I summarizes the patient's impact on the clinician. The essence of certain forms of many severe paranoid conditions is that the patient strives to appear hypernormal. When we assign this Level I diagnosis, we do not assume that this means the patient really is normal, but rather that his security operations at this level strive to create this impression.

Very often patients reporting to an out-patient clinic after hospitalization for a psychotic break present as hypernormal at the level of symptoms. These patients have utilized repressive measures to handle their psychotic impulses. They are sitting on their conflicts and striving to maintain a façade of conventional strength. The multilevel pattern and the clinical interview will usually indicate how precarious or brittle these surface operations are.

In summary it can be said that whatever the reason bringing the hypernormal patient to the clinic, it is seen by him as an annoying appendage separate from his perception of his own personality. This situation makes the "88" patient a particularly tricky prognostic problem.

Standard Psychiatric (Kraepelinian) Equivalents of the Hypernormal Personality

There appears to be no standard psychiatric diagnosis which covers the behavior described in this chapter. Psychiatric literature has traditionally neglected the normal, the superior, and the supernormal personality, and those who present these operations.

Before the increasing popularity of psychosomatic concepts, the "88" personality type did not appear in the psychiatric consulting rooms. The early psychiatric theories and nosologies were clinical in origin. The overtly strong, popular, protective personality failed to receive conceptual attention.

The Kaiser Foundation clinic (because of its consultative relation to a general hospital) has evaluated hundreds of patients whose overt and conscious behavior is hypernormal. The Foundation's research in psychosomatic medicine has collected multilevel test batteries on more than one thousand of these cases.

Analysis of these protocols has led us to view strong, affiliative, supportive security operations not as ideal or normal ways of behaving

but as machinery for warding off anxiety, avoiding disapproval, and raising self-esteem. There are several hundred multilevel patterns of behavior which can underly a hypernormal façade. Some of these patients might be given psychiatric or psychosomatic labels (depending on their specific symptomology). Some of them are psychotic individuals (usually paranoid) who desperately cling to an overt appearance of adjustment. Many of them would remain undiagnosed according to current psychiatric nosology and, if labeled at all, would be called "normals."

Research Findings Characteristic of the Hypernormal Personality

The Kaiser Foundation research has studied several hundred subjects with the Level I diagnosis of responsible-hypernormal personality. Here is a summary of current findings.

1. Forty-three per cent of all patients with psychosomatic symptoms fall in the *NO* octant at Level I. Psychosomatic patients therefore use these hypernormal operations three or four times more than chance expectancy.

2. Fourteen per cent of nonpsychosomatic psychiatric patients fall in this sector. These patients, therefore, do not use these operations more than chance expectancy.

3. Hypernormal operations are characterized by the following MMPI pattern: high scores on hypochondriasis (Hs), repressive blandness (Hy), denial of pathology (K), low scores on nonconformity (F), depression (D), schizoid (Sc), and obsessive tendencies (Pt).

4. These patients are not well motivated for psychotherapy. They rank as the lowest group in average number of therapy sessions. This indicates that they refuse treatment or quit soon after beginning. Pure or stable hypernormals remain in treatment on the average of six sessions. Conflicted hypernormals remain in treatment about twice as long (average equals eleven sessions). Here the underlying trends (of weakness or bitterness) make them more likely to remain in therapy.

5. They are highly identified with their parents. In our study of conscious identification with mother, father, and spouse, they rank first; and on another study, second among the eight diagnostic groups.

6. Hypernormal patients (along with hysterics) tend to misperceive the interpersonal behavior of others in a consistent direction. They attribute too much friendliness and cooperativeness to others. They also tend to see others as stronger than they are consensually judged to be. This indicates that responsible personalities consistently tend to see others as like themselves—falsely perceiving others as more loving and strong than they are. This is unquestionably a function of their attempt to maintain a bland, conventional atmosphere which

fails to take into account the actual amount of hostility-weakness present in others as well as themselves.

7. The hypernormal personality type appears in certain cultural and institutional samples much more frequently than in others. The percentage of responsible individuals in various samples at Level I-M is presented in Table 24.

TABLE 24

PERCENTAGE OF RESPONSIBLE-HYPERNORMAL PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Responsible-Hypernormal Personalities*
Psychiatric Clinic Admissions	537	22
College Undergraduates	415	33
University Psychiatric Clinic	133	31
Middle Class Obese Patients (Female)	121	36
Overtly Neurotic Dermatitis Patients	31	23
Self-Inflicted Dermatitis Patients	57	33
Unanxious Dermatitis Patients	71	29
Group Psychotherapy Patients	109	19
Individual Psychotherapy Patients	49	12
Hypertensive Patients	49	54
Ulcer Patients	43	48
Medical Control Patients	37	38
University Counseling Center	93	39
University Graduate Students (Male)	39	31
Stockade Prisoners (Male)	52	25
Hospitalized Psychotic Patients	28	14
Officers in Military Service	39	49
Total	1903	

The percentage figures expected by chance for these groups is 12.5. The psychiatric sample contains more than the expected percentage because the Kaiser Foundation clinic services a general hospital and four additional medical centers. The number of patients with somatic and psychosomatic referrals is much greater than that seen in the standard psychiatric clinic. The clinic policy of referring certain naïve, conventional, or hypernormal patients to group therapy for educational reasons accounts for the fact that a higher percentage of responsible patients are seen in group therapy.

In general it will be noted that the nonclinic samples of "normal" subjects (e.g., army officers) contain three to four times the expected percentage of hypernormal subjects.

8. The percentage of responsible-hypernormal individuals in various samples at Level II-C is presented in Table 25. It will be observed that the psychosomatic samples tend to have three times the expected number of hypernormal patients. The ulcer sample and the neuro-

dermatitis samples, whose respective tendencies towards aggression and masochism have been previously noted, are exceptions to this generalization. The fact that a fairly high percentage of psychotics claim to be hypernormal is an interesting finding, the significance of which is discussed in Chapter 23.

TABLE 25

PERCENTAGE OF RESPONSIBLE-HYPERNORMAL PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Responsible-Hypernormal Personalities*
Psychiatric Clinic Admissions	207	15
Hospitalized Psychotic Patients (Male)	46	15
Group Psychotherapy Patients	101	16
Individual Psychotherapy Patients	38	11
Overtly Neurotic Dermatitis Patients	31	13
Self-Inflicted Dermatitis Patients	56	21
Unanxious Dermatitis Patients	70	33
Medical Control Patients	41	27
Ulcer Patients	42	14
Hypertensive Patients	49	33
Middle Class Obese Patients (Female)	100	36
Total	781	

9. Hypernormal patients see their fathers as exceedingly strong-conventional people. The father is consciously idealized. The mother is seen as extremely loving, tender, and agreeable. A most conventional portrait of both parents is produced. They also see their marital partners as conventional, friendly—but slightly more docile than their conscious picture of their mothers. The conscious descriptions of all three family members are located on the conventional side of the diagnostic grid.

10. Of all the "88" patients seen in the psychiatric clinic over a one year period, 74 per cent *did not* go into psychotherapy. By comparison only 46 and 48 per cent of distrustful and masochistic patients did not go into therapy. This lends empirical support to the statement that hypernormal subjects are not initially well motivated for psychotherapy.

20

Adjustment Through Power: The Autocratic Personality

Power, success, and ambition as means of warding off anxiety and increasing self-esteem comprise the theme of this chapter. We shall consider those individuals whose overt interpersonal operations stress compulsive energy, authority, and dominance over others. This is the "11" personality type.

Until recently, these patients were not often seen in psychiatric consulting rooms. The nature of their security operations is such that they were not seen as needing psychiatric help and would hardly consider asking for help.

Adaptive Forms of the Power-Oriented Personality

Adjustment through power can be an adaptive and successful way of life. Included here are those persons who express strength, force, energy, and leadership, and who win from others respect, approbation, and deference.

The generic idea of *hero* belongs to this mode of adjustment. So do all forms of ambition. So do the traits of energy, planful organization, and righteous authority. Behavior which is designed to excite admiration or to provoke submission from others can be considered as diagnostic of this security operation.

There are many ways in which power can be manifested. Physical strength, especially in the case of the male, is a means of winning respect. Intellectual strength is another common power operation. The sage, the wise man, and the savant are all roles which earn respect. The interpersonal mechanism of teaching is, in fact, probably the most common manifestation of power motivation. The ordinary, commonplace frequency of the teaching behavior makes its power implications go unnoticed. It seems clear, however, that whenever one person be-

gins to instruct, inform, or explain to another, he is conveying the interpersonal message, "I know something you do not know; I am wise and better informed on this subject than you." Intellectuals are often power-oriented individuals who maintain illusions of strength and prestige through their knowledge. The nonintellectual who cannot understand why teachers seek out and remain in positions of such low pay may fail to recognize the rewards and securities which accrue to the pure undiluted power expression of the pedagogue.

Teaching is thus a most adaptive and constructive manifestation of the autocratic impulse.

In addition to physical and intellectual strength, there are several other ways in which power can be gained and expressed. Social status is perhaps one of the most effective means of exerting authority. Prestige—either bureaucratic or social—is a power magnet for attracting respect and deference.

Financial strength is another common form of power expression. Most forms of conspicuous consumption are diagnostic of the attempt to maintain a superior (22) or powerful (11) façade.

In summary it can be said that the "11" personality is characterized by energetic, organized behavior, by the attitude of knowledge, competence, strength, and authority.

Maladaptive Forms of the Power-Oriented Personality

The extreme forms of this way of life are characterized by autocratic, domineering behavior. Compulsive attempts to control are diagnostic of this maladjustment. So is power-ridden, overambitious behavior. Pedantry falls into this category; as do status-driven attempts to impress.

The person who tries to overorganize his life and the lives of those around him is utilizing maladaptive power operations. The compulsive person is often striving to increase his façade of competence and efficiency. His exaggerated attempts to be planful, precise, and correct are diagnostic of the "11" maladjustment.

The key factor in this maladaptive type is the complete avoidance of weakness and uncertainty, and the compulsive endeavor to appear competent, organized, and authoritative.

The autocratic person exhibits his power-oriented machinery of adjustment rigidly whether it is appropriate to the situation or not. He cannot relax his compulsive, energetic operations. In social or recreational contexts he grimly clings to his mantle of efficiency and competence however uncalled-for it may be. The extremes of this type of maladjustment often involve hyperactivity and manic behavior.

In the clinic the autocratic individual is thus easily diagnosed by his inappropriate responses. He does not act like a patient coming for help—but as a strong competent person seeking to inform or impress the clinician.

The Purpose of "11" *Behavior*

Individuals select power-oriented security operations because they have found them to be effective in warding off anxiety. They feel secure when they are exerting control over people and things. They apparently dread the possibility of being weak, uninformed, submissive.

The rewards and comforts which can be obtained through control and power are numerous. The strong person feels defended and protected. He wins awe, admiration, and obedience from others. He gains a feeling of certitude and organization—which serve as an illusory buffer against the mysteries and uncontrollable possibilities of existence.

The autocratic individual is, we assume, made most anxious when he feels uncertain, confused, or passive. He attempts to maintain security and self-esteem and to avoid derogation and hurt by means of his power-oriented operations.

The Effect of "11" *Behavior*

The façade of power and control provokes others to obedience, deference, and respect from others. This is to say, *AP* pulls *IJ*.

In most situations the person who manifests wisdom is looked to for advice. The person who demonstrates planful control and competence is respected.

This principle of reciprocal interpersonal relations is, of course, a probability statement. It can be altered by the personality of the other person. Thus a managerial person interacting with another who uses the same interpersonal reflexes may generate a power struggle. He may receive agreeable cooperation from a person with hysterical operations.

In general it will be found that rigid autocratic individuals seek out docile admiring followers. They are most comfortable when they are paired with those who symbiotically match their interpersonal reflexes—who flatter, obey, and respect them.

Clinical Manifestations of Managerial Power

It has been pointed out that prior to the 1930's the managerial personality was not a frequent visitor to the psychiatric clinic. In recent years, however, a broader definition of neurosis (as any form of ex-

treme or maladaptive behavior) has developed. In addition, the concepts of psychosomatic medicine have stressed the point that certain physical symptoms can be manifestations of maladaptive conflicts.

For these reasons, more and more patients whose overt façade stresses power and energy are being referred for psychiatric diagnosis. There are several specific clinical characteristics of the power-oriented personality.

Psychosomatic symptoms are a most common complaint. Ulcer patients are classically seen as driving, ambitious, energetic people. Certain dermatitis diagnostic groups utilize strong interpersonal reflexes. Overweight women tend to present clinically in the same manner. Asthmatic men tend to stress power and deny weakness in their approach to a psychiatric clinic.

Some strong managerial individuals come to the clinic because of their concern about other family members. One frequent type of referral involves the competent, industrious woman who is married to a weak, delinquent, or rebellious husband. The managerial wife comes partially seeking the clinic's support in getting her husband into treatment and partially because of her own underlying passive needs. This type of strong woman inevitably manifests "preconscious" masochism and is usually involved in a complicated guilt-power conflict with her husband.

Many cases of alcoholism or gambling present a power-oriented façade to the clinic. These patients see their symptomatic behavior as isolated from their character structure and are not initially well motivated for therapy. The prognosis in these cases depends upon the ability to tolerate consideration of their underlying rebellious or passive feelings.

Another symptom typical of the "11" personality involves an isolated anxiety attack. The patient regularly uses compulsive, energetic, self-confident operations to handle anxiety. This façade may temporarily crack (in response to a particularly threatening environmental circumstance). The patient comes to the clinic because he is scared by the possibility of a recurrence. (An anxiety attack or any other sign of weakness is, of course, the most paralyzing catastrophe to the person who utilizes power security operations.) By the time the patient comes for his intake interview, his routine compulsive reflexes may be working smoothly again. He mobilizes against the threat of anxiety created by psychological exploration and presents a façade of competent strength. These patients see their anxiety attacks as isolated events, not integral to their strong character structure. The latter they do not usually want to change.

Some managerial personalities (male) come to the clinic with symptoms of impotency. The façade of strength is particularly disturbed by sexual inadequacy. Generally these patients are eager to have the symptoms (which are uncomfortable signs of weakness) removed and are not pressing to explore the underlying passivity or fear which the symptoms represent.

Occasionally some "11" types come to the clinic because of dissatisfaction with their interpersonal relationships with others. The competent wife puzzled by her errant husband has been mentioned. The compulsive, righteous husband frustrated by a rebellious wife, or by resentful children, is another example. Now and then compulsive patients come under pressure from their employers who threaten to fire them because of friction generated by their power strivings. A particularly sad variety of managerial operations is afforded by the masculine, driving woman who finds herself lonely and neglected by men and who hopes to find relief from her vague dissatisfaction with self without relinquishing her compulsive protections.

There is one exception to this generalization. Some highly intelligent, psychologically sophisticated individuals come to the clinic seeking intensive treatment or psychoanalysis. These patients are actually hoping to change their character structure. They may have some of the symptoms mentioned above and are insightful enough to want therapeutic help. These patients are intellectually (and not emotionally) motivated for psychotherapy. They will exhibit their power reflexes but have enough insight to ask for and remain in treatment. Such patients are usually referred to psychoanalysts or assigned to intensive psychotherapy.

Relationship of Power-Oriented Personality to Standard Psychiatric Diagnostic Types

Although adjustment (or maladjustment) through power has not classically been the focus of much psychiatric theory, there are two diagnostic types which have some of these interpersonal factors implicit in their definition.

The *compulsive* personality seems to involve definite power motives. The compulsive person is one who is active, prompt, well-organized, industrious, pedantic, planful, and often righteously competent. The person who exhibits these traits is clearly trying to impress others with his effectiveness. (The fact that he is generally trying to deal with his own inner feelings of guilt or impotency may appear in the form of multilevel conflicts which often characterize the compulsive patients seen in the clinic.)

Successful, well-adjusted compulsives are generally respected by others for their diligence and organization. The notion of efficiency (for the American and German cultures, at least) is heavily loaded with power connotations. In Chapter 16 we have attempted to distinguish between the obsessive and the compulsive modes of adjustment. It was suggested there that these two behaviors are quite distinct in terms of symptom and interpersonal meaning to others.

The obsessive person usually presents as guilty, passive, and uncertain. The compulsive as strong and right. While their security operations are different, they can sometimes be seen in the same personality pattern, usually when the compulsive defenses are breaking down.

The specific power elements of the compulsive state have not been made the central diagnostic key—usually being subordinated to symptomatic factors. Some of the dominance-submission aspects of compulsivity are implicit in certain psychoanalytic writings. Freud's first and most authoritative paper on the compulsive character was published in 1908 (2). At this time he presented his conception of the three anal characteristics: orderliness, parsimony, and obstinacy. In the paper "Character and Anal Eroticism" he first described the first great power struggle of life: children's "great self-will about parting with their stools." He then describes the parents typical attempt to "break his (the child's) self-will and make him submissive." Fenichel (1, p. 280) sees the anal character trait of orderliness as "the elaboration of obedience."

Most psychoanalytic writers tend to agree as to the power elements of the compulsive personality but draw psychosexual rather than interpersonal conclusions. Compulsivity is thus seen as a reaction formation against the child's stubborn, managerial wish to foil the parent by soiling.

Mullahy (3, p. 61) has presented a summary of the resolution of this archaic power struggle which is very congenial to the interpersonal theory. He points out the strivings for "self-determination" associated with anal activities and then makes the additional (and crucial remark): "When the child succeeds in making a virtue out of necessity, he is said to identify himself with the requirements of his educators and is proud of his attainment. Thus, the primary injury to his narcissism is compensated, and the original feeling of self-satisfaction in being 'good.'"

Compulsivity (through identification) thus provides the individual with the feeling of power and righteousness.

This relation between self-satisfaction and power is confirmed by the empirical findings of the Kaiser Foundation research. Managerial

personalities are most closely identified (consciously) with their parents. They are closely identified with their ego ideals. They are pleased with themselves.

Obsessive patients, on the contrary, are the most self-disapproving and are least identified consciously with their ego ideals.

A clinical description of a personality type which seems similar to the managerial personality has been presented by Frank *et al.* (4, p. 215) They entitle this behavior pattern the *doctor's assistant*, which they say, ". . . consists of a patient's tendency in the group to defend authority, to please the doctor, to offer advice to other patients, to hide his own weaknesses, and generally to impress everyone with his own excellence. This behavior springs from an idealization of authority in general and a conviction that the way to win an authority's good will is to demonstrate one's loyalty and excellence."

Research Findings Characteristic of the Managerial Personality

The Kaiser Foundation research has studied over 2,000 psychiatric clinic patients and over 1,000 psychosomatic and normal subjects. The managerial type (at Level I) comprises the largest percentage of cases studied. Over 600 patients who employ these security operations have been diagnosed. We shall now consider some of the current research findings characteristic of this personality type.

1. Twenty-three per cent of patients with psychosomatic symptoms (i.e., ulcer or hypertensive) fall into the managerial sector at Level I. Only 8 to 13 per cent of nonpsychosomatic patients (i.e., patients with classic neurotic symptomatology) are given the diagnosis of power-oriented personality. This tends to confirm the suggestion that managerial patients do not tend to come to the clinic or enter psychotherapy with overt psychopathological symptoms.

2. Patients who consciously describe themselves as managerial have a characteristic MMPI profile. They manifest high scores on the hyperactivity scale (Ma) and the denial of symptoms scale (K), and low scores on depression (D) and obsessive tendencies (Pt). They do not stress emotional symptoms.

3. Managerial patients do not tend to enter or remain in psychotherapy. They are seen in treatment on the average of six sessions. They rank lowest (tied with hypernormal and narcissists) on number of times seen in the psychiatric clinic. They are, therefore, not initially well motivated for psychotherapy.

4. Managerial patients tend to be closely identified (consciously) with their parents. On one study they rank first in closeness of identification with mother; and on a second study they rank second on this variable (being topped only by hypernormals).

5. They are closely identified with their marital partners. They rank second in this variable. Only the hypernormal group claims a closer connection with their spouses.

6. Managerial patients (along with narcissists) have a characteristic misperception of the interpersonal behavior of others. They attribute too much weakness to others with whom they interact. They seem to look down on others and fail to perceive strength in others.

7. The managerial personality tends to appear in certain cultural and institutional settings with varying frequencies. Table 26 presents the percentage figures for Level I-M. The percentage expected by

TABLE 26
PERCENTAGE OF MANAGERIAL-AUTOCRATIC PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Managerial-Autocratic Personalities*
Psychiatric Clinic Admissions	537	15
College Undergraduates	415	45
University Psychiatric Clinic	133	13
Middle Class Obese Patients (Female)	121	30
Overtly Neurotic Dermatitis Patients	31	22
Self-Inflicted Dermatitis Patients	57	25
Unanxious Dermatitis Patients	71	36
Group Psychotherapy Patients	109	13
Individual Psychotherapy Patients	49	8
Hypertensive Patients	49	18
Ulcer Patients	43	21
Medical Control Patients	37	35
University Counseling Center	93	38
University Graduate Students (Male)	39	31
Stockade Prisoners (Male)	52	19
Hospitalized Psychotic Patients	28	14
Officers in Military Service	39	46
Total	1903	

chance for these groups is 12.5. It will be noted that all groups except the two psychotherapy samples contain much more than the expected frequency of managerial personalities. The norms on which these interpersonal diagnoses are based were taken from a sample of 807 psychiatric clinic admissions. The results listed in Table 26 suggest that more than three times as many military officers manifest power-oriented operations than do clinic admission patients. Fifteen per cent of admissions to the Kaiser Foundation psychiatric clinic exert strong compulsive symptomatic pressure on the clinic. Only 8 per cent of individual therapy patients utilize these overt operations, which tends to confirm the statement that managerial compulsive patients come to the clinic for diagnosis (and perhaps symptomatic relief) but

do not tend to enter psychotherapy. The larger percentage (13 per cent) of managerial patients in group therapy is caused by the clinic's policy of placing certain psychosomatic patients (e.g., ulcer patients) in group treatment.

8. The frequency figures for the occurrence of the managerial personality at Level II-C are presented in Table 27. Three psychosomatic groups (ulcer, hypertensive, and obese) claim to be stronger by a ratio of over 4 to 1 than normal controls. A fairly large percentage of psychotic patients attempt to maintain the conscious illusion of executive power. Patients who end up in individual psychotherapy are, as noted before, docile and less managerial in their façade operations.

TABLE 27

PERCENTAGE OF MANAGERIAL-AUTOCRATIC PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Managerial-Autocratic Personalities*
Psychiatric Clinic Admissions	207	12
Hospitalized Psychotic Patients (Male)	46	17
Group Psychotherapy Patients	101	12
Individual Psychotherapy Patients	38	8
Overtly Neurotic Dermatitis Patients	31	10
Self-Inflicted Dermatitis Patients	56	13
Unanxious Dermatitis Patients	70	11
Medical Control Patients	41	7
Ulcer Patients	42	33
Hypertensive Patients	49	33
Middle Class Obese Patients (Female)	100	32
Total	781	

9. Managerial patients tend to see their mothers as exceedingly strong, independent people. They also describe their fathers as strong, but not as powerful as their mothers. They describe their marital partners as much more passive and agreeable than their parents.

10. Sixty-eight per cent of all managerial patients seen in the psychiatric clinic (over a one-year period) *did not* go into treatment. This indicates that this personality type is not initially well motivated for psychotherapy. (By contrast 46 per cent of distrustful patients did not go into therapy.)

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21

Adjustment Through Competition: The Narcissistic Personality

In this chapter we shall consider a way of life which is based on competitive self-confident narcissism. This is the "22" mode of adjustment. This personality type is of particular interest because it appears very rarely in the psychiatric clinic and has been given scant theoretical attention in proportion to the frequency of its occurrence.

The "22" personality expresses at Level I a clear love and approval of himself. He acts in a strong, arrogant manner. He communicates the message that he feels superior to the "other one." He appears independent and confident.

In its adaptive intensity this interpersonal reflex is a most impressive social maneuver. In its maladaptive extreme it becomes a smug, cold, selfish, exploitive social role. In this case the adaptive self-confidence and independence become exaggerated into a self-oriented rejection of others. The individual is so rigidly tied to his own self-enhancement that he fails to sense the inappropriateness of his behavior.

Exhibitionism and proud self-display are often diagnostic of this personality type. This competitive attitude may show itself in dress, carriage, and gesture, or in the purposive meaning of verbalizations. The kind of narcissistic expression varies from person to person. Some narcissists stress their intellectual superiority. Others (more typically women) center their overt narcissism on their appearance, dress, and physical beauty. Conspicuous consumption is generally related to this security operation as well as all forms of snobbishness.

The Purpose of Competitive Narcissism

Narcissistic displays of superiority are a means of warding off anxiety through ascendance and self-enhancement. These individuals feel most secure when they are independent of other people and feel they are triumphing over them.

These individuals depend for their self-esteem on the demonstration of weakness in others and competitive strength in themselves. This security operation is close to the managerial-autocratic. The difference lies in the amount of positive or affiliative affect involved. The executive personality wants loving respect and obedience. The narcissist provokes defeated envy and inferiority feelings. The narcissist puts more distance between himself and others—he wants to be independent of and superior to the "other one." Dependence is terrifying.

Another familiar variety of the competitive mode of adjustment is seen in the case of the status-driven person. These individuals are unusually sensitive to issues of superiority-inferiority. They invest considerable energy in protecting and increasing their prestige. This concern with status is also typical of the managerial personality. The latter, however, tends to provoke others to yield authority to him willingly through recognition of his strength. The competitive person is generally more ruthless and exploitive in his attempts to seize and maintain superiority and pulls a less willing submission from others. To put it in different terms—the managerial person trains others to identify with his strength and gives the impression that his power will be used either neutrally or to help the weaker. The narcissistic person tends to emphasize his superior difference from the "other" and gives the impression that his status and strength will be used to shame or humiliate the "other."

Competitive persons are apparently made most anxious by the threat of weakness or dependence. Weakness is generally sensed by these individuals to be a dangerous or humiliating position. Often the experiences of childhood have been so traumatic as to lead to a counteraction in the direction of strength. In other cases dependence is associated with crucial figures with whom the subject desires to disidentify. Thus the counterphobic man equates docility with passivity. The competitive woman may attempt to act the opposite of a submissive parent whose passivity is consciously perceived as a negative trait.

The specific purpose of independent arrogance is to establish a superior invidious relation with others. These subjects apparently view passivity, cooperation, trust, or tenderness as dangerous. They seem to fear the loss of proud individuality which is attached to these other operations.

There are, of course, many rewards associated with self-confident narcissism. Self-approval can be a pleasant experience. The person who bases his security on overt independence is comforted by the satisfaction in flexing his muscles, admiring his own strength or beauty or wisdom, and reveling in his advantages over those whom he per-

ceives as inferior. Adaptively self-confident individuals receive considerable admiration and social approval.

In the maladaptive extreme, the narcissist seems driven to inflate himself compulsively at the expense of others. This brand of abnormality leads to destructive activities. The severe narcissist cannot tolerate success or strength in others. He is driven to compete, to exhibit, to exploit. He is consistently rejecting and selfish. His compulsive and frantic attempts to boast lead to a most unrewarding circle of activities. As the narcissism becomes more flagrant, it fails to win respect; and this frustration leads to increased exhibitionistic maneuvers.

The maxim of this form of maladjustment is: "How can I establish superiority over this person? How can I defeat him? How can I use him for my selfish enhancement?"

The Effect of "22" Behavior

Competitive, self-enhancing behavior pulls envy, distrust, inferiority feelings, and respectful admiration from others. In the language of the interpersonal system, *BC* provokes *GHIJ*.

The adaptive person who uses this security operation in a sensitive manner wins the admiration and flattering envy of others. They look up to him and pay him the tribute of a grudging, envious approval. It may be helpful to contrast the interpersonal world created by the competitive person with the response which the executive, dominating person provokes. The latter is more conventional and responsible in his use of power. He tends to train others to obedience or loving respect. The competitive person strives to impress others that he has what they want. There is more disaffiliative motive in his approach and he generally receives therefore a passively hostile, negative submission.

These generalizations are, of course, probability statements. The response of the "other one" is determined partly by his own interpersonal reflexes. Thus a rigidly docile, agreeable person may manifest the most friendly responses to a narcissist's approach. An inflexibly competitive person will react to another narcissist not with humble defeated envy but with an increase in his own independent reflexes. A fierce exhibitionistic competition between the two often results. Thus the principle of reciprocal relations (which in this case reads *BC* pulls *GHIJ*) will be found to work in most cases but does not hold where inappropriate narcissism characterizes the subject or other rigid reflexes characterize the other.

Clinical Manifestations of Competitive Narcissism

Narcissistic patients rarely come to a psychiatric clinic for diagnosis or therapy. In one study of 537 routine admissions to a psychiatric clinic only 6 per cent were diagnosed competitive or narcissistic at the level of symptomatic presentation. There are fewer narcissists in clinic samples than any other diagnostic type.

The psychiatric clinic is thus not the natural habitat of the competitive, independent person. The reason for this finding seems clear. The emphasis on proud self-enhancement is quite incongruous with seeking psychiatric help. The very essence of this mode of adjustment is that "22's" ask help from no one, need no assistance, and are getting along quite well on their own steam.

The "22" patients who do show up in the clinic generally come for one of three reasons: (1) psychosomatic symptoms, (2) current injuries to their narcissism, (3) the desire to display their personalities or to talk about themselves.

Patients who are referred to the clinic for ulcer or asthmatic symptoms often present independent, narcissistic façades. The diagnostic location for the average ulcer patient (at Level II-C) is in the *BC* (narcissistic-competitive) octant. Many of these patients tend to stress proud, hardboiled self-sufficiency. The same is true of asthmatic patients.

The second group of competitive patients seen in the clinic are those whose self-regard has received a recent defeat. They often report the most colorful and fearful symptomology. They often list dozens of symptoms and may recount their eccentricities and life histories in great detail. The superficial impression of depression or dependence is deceptive. Psychological testing or perceptive interviewing will reveal that the patients are not as anxious or depressed as they appear. What becomes evident is a narcissistic concern with their own reactions, their own sensitivities. The precipitating cause for their entrance to the clinic is usually a shift in their life situation, which causes frustration or a blow to their pride. The birth of a child may cause the narcissistic woman to become upset over the new demands of responsibility, nurturance, and the loss of attention. Narcissistic people in general react negatively to parenthood and intense conflicts may appear in this connection. One way in which this conflict can be handled is for the subject to incorporate the child into the circle of his or her own narcissism and thus share attention with the child.

Occupational changes which lower public esteem or create dependency or require a tender approach may produce tensions in com-

petitive men. Phallic, exhibitionistic men are often forced to retire to more sedentary, conventional occupations with accompanying pain and tension. This phenomenon was quite common after the last war when aviators, combat soldiers, etc., were faced with the loss of the gratifications of their positions.

The histrionic character of this personality type often leads such individuals into activities which involve public display—modeling, acting, and other forms of social exhibition. Any shift in their life situation which involves the relinquishment of these rewards can make tension and symptoms and lead to psychiatric referral.

Many competitive men are most comfortable when they are holding independent positions—running their businesses, etc. Failures in those activities, which create a feeling of weakness or require them to take subordinate posts, can lead to increased anxiety and possibly physical symptoms.

Another very common reason which brings the narcissistic persons into the psychiatric clinic is their intense interest in, concern for, and love of themselves. Many people perceive therapy as a unique opportunity to talk about themselves, to spin theories about themselves, and to engage the interest and attention of a respected person (the therapist) in the subject that is dearest to the narcissist's heart.

These three factors—physical symptoms, narcissistic injury, and self-fascination—seem to account for the motivation of those few competitive characters who come to the clinic. They lead to the paradoxical situation of patients who are not really depressed or dependent applying for psychiatric help.

Narcissists do not provide difficult problems for diagnosis if the intake worker focuses on the purposive meaning of their communications and is not diverted by dramatic (but not deeply felt) symptomology. These patients are trying to impress the "other one." They may do this by muscle-flexing, boasting, seductive and colorful case histories, flirtatious maneuvers, or outright competition with the clinician.

There are certain psychometric signs characteristic of this personality type. On the MMPI, the anxiety and passivity scales (D and Pt) are low. The imperturbability scale (Ma) is high. Physical symptoms may push the Hs scale up. The conventionality-isolation scales are neither markedly high nor low. Thus F and Sc are not as high as in the case of the psychopath and schizoid. The conventionality scales K and Hy are not as pronounced as in the case of the psychosomatic and hysteric.

Standard Psychiatric Definition of the Narcissistic Maladjustment

In most of the preceding diagnostic chapters it has been possible to relate the interpersonal type of maladjustment to a standard psychiatric category. Distrust defines the schizoid; docile dependency defines the phobic, etc. This relationship between interpersonal and psychiatric diagnosis does not hold in the case of the autocratic person, who has received relatively little attention from clinical theorists. These dominating, power-oriented persons do not tend to come for help, and have thus been neglected in the psychiatric literature.

The same situation holds for the "22" personality. There is objective evidence indicating that this personality type does not often come to the clinic. There is, therefore, not a commonly agreed or Kraepelinian-type term for categorizing these persons.

This mode of maladjustment has, however, not been completely neglected by psychiatric writers. The psychoanalytic theory tends to focus not on the symptomatic factors (which are stressed by the preanalytic psychiatrists) but stresses the multilevel aspects of character structure. This much more sophisticated approach considers character traits as means of warding off anxiety or instincts. The psychoanalysts have always recognized that self-love and independent narcissism form a common and effective way of warding off or counteracting underlying feelings of weakness.

The term *counterphobic* is often employed to describe the exhibitionistic personality who compulsively attempts to demonstrate his superiority.

Fromm has defined the *exploitive character* as one who attempts to better himself at the expense of others.

Horney sees narcissism as one of the basic neurotic "trends." The narcissistic person, as defined by Horney, inflates himself and aggrandizes himself at the expense of others.

Jerome Frank and his colleagues have described three behavior patterns seen in psychotherapy groups which are very close to three of the interpersonal types presented in this book. The help-rejecting complainer and the doctor's assistant have been referred to in Chapter 15 and Chapter 21, respectively.

A third interpersonal type isolated by Rosenthal, Frank, and Nash (1, pp. 217–18) is called the *self-righteous moralist.* This mode of behavior is quite similar to that being described in this chapter. These authors describe this type as follows:

> The most outstanding characteristic of the self-righteous moralist, as exemplified by these patients, is the need to be right or to show up the other fellow as wrong, particularly when some moral issue is involved which impinges on his own system of values. . . .

In the very first group meeting, the self-righteous moralist tends to present himself as one who is calm, controlled, and self-contained, indicating his superiority by a show of poise. He usually manages to become the focus of the discussion by his intensity, by dramatizing whatever he has to say, and by laboring his position indefinitely, refusing to concede any point, to admit any error, or to make any modification of his original formulation. . . .

When symptoms, problems, and personal history are discussed, he talks of these in such a way as to enhance his own status: for example, he says that he has survived worse distress than others; that he has carried on in his duties despite his illness; that others are sicker than he is; and that others can profit from learning how he has handled his problems. . . .

Schafer (2) has given more attention to the narcissistic personality than any other clinically oriented writer. As diagnostic cues he stresses "striking egocentricity," a tendency to avoid anxiety-arousing situations (i.e., they do not like to exhibit behavior *HI* on the diagnostic circle). Schafer also mentions exhibitionism and overdemonstrativeness, which he believes to be a cover-up of "basic coldness and distance." In general it appears that the character disorder defined by Schafer is close to the narcissistic type of maladjustment described in this chapter.

Research Findings Characteristic of the Narcissistic Personality

In the preceding discussion of the narcissistic personality we have leaned upon and referred obliquely to research findings of the Kaiser Foundation project. Some of these results will now be summarized.

TABLE 28

PERCENTAGE OF COMPETITIVE-NARCISSISTIC PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Competitive-Narcissistic Personalities*
Psychiatric Clinic Admission	537	6
College Undergraduates	415	9
University Psychiatric Clinic	133	10
Middle Class Obese Patients (Female)	121	10
Overtly Neurotic Dermatitis Patients	31	0
Self-Inflicted Dermatitis Patients	57	7
Unanxious Dermatitis Patients	71	7
Group Psychotherapy Patients	109	4
Individual Psychotherapy Patients	49	10
Hypertensive Patients	49	2
Ulcer Patients	43	5
Medical Control Patients	37	8
University Counseling Center (Male)	93	4
University Graduate Students (Male)	39	21
Stockade Prisoners (Male)	52	13
Hospitalized Psychotic Patients	28	11
Officers in Military Service	39	0
Total	1903	

1. Patients who manifest competitive operations at Level I (MMPI) and in the rated interpersonal reflexes (sociometrics) do not have psychosomatic symptoms (except for the ulcer group).

2. Ulcer patients are the psychosomatic group who stress competitive independence in their Level II self-descriptions.

3. Competitive patients have MMPI profiles with low scores on depression (D) and obsessive rumination (Pt) and relatively higher scores on manic imperturbability (Ma).

4. These patients do not tend to come to the psychiatric clinic. This diagnostic group is the least likely to accept a psychiatric referral.

5. This personality type is found in other cultural samples more frequently than in the psychiatric clinic. As indicated in Table 28 there are ten samples which contain more narcissists at Level I-M than the Kaiser Foundation clinic admission group. University graduate students contain the most competitive personalities, followed by stockade prisoners and university psychiatric clinic patients.[1]

6. The Level II-C self-diagnoses of several samples are listed in Table 29. Comparison of Tables 28 and 29 is made difficult by the fact that the two samples which contained the greatest number of narcissists at Level I-M (graduate students and prisoners) were not included in the Level II-C study. At the level of conscious self-description, overtly neurotic dermatitis patients claim the most competitive self-confidence and the group-therapy patients (who emphasize schizoid distrust) and self-inflicted dermatitis patients (who stress conventionality) claim the least narcissism.

7. Narcissists are not especially motivated for psychotherapy. One sample of these patients came on the average for six therapeutic interviews. This ties them for last place among diagnostic groups in terms of length of treatment. Female narcissists, incidentally, seem to stay in therapy longer than male narcissists.

8. Competitive patients tend to be consciously disidentified with their parents. They are more identified than schizoids and psychopaths but clearly less identified than the managerials, psychosomatics, hysterics, and phobics.

9. The same findings hold for conscious marital identifications.

10. Narcissistic patients tend to describe their parents as being relatively sadistic.

[1] The fact that the military officer sample contains no narcissistic subjects would seem to be a contradiction to the previous statements which claimed that exhibitionistic characters are often located in military pursuits. The military officer group included here was tested under assessment circumstances which probably influenced their test-taking attitude and their resulting symptomatic scores. These officers were assessed in a nonclinical, quasi-military situation where there would be little pressure to stress narcissistic, unconventional feelings and some motivation to emphasize responsible executive traits, which they did.

TABLE 29

PERCENTAGE OF COMPETITIVE-NARCISSISTIC PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Competitive-Narcissistic Personalities*
Psychiatric Clinic Admissions	207	14
Hospitalized Psychotic Patients (Male)	46	11
Group Psychotherapy Patients	101	7
Individual Psychotherapy Patients	38	11
Overtly Neurotic Dermatitis Patients	31	17
Self-Inflicted Dermatitis Patients	56	9
Unanxious Dermatitis Patients	70	11
Medical Control Patients	41	10
Ulcer Patients	42	14
Hypertensive Patients	49	12
Middle Class Obese Patients (Female)	100	12
Total	781	

11. They describe their marital partners as agreeable, admiring people. This suggests that they tend to marry people whom they see as weak, docile, and who will pay them respectful tribute.

12. On the Naboisek study of interpersonal misperception the competitive-exploitive group (along with the managerials) reveals marked misperceptions of weakness in others. They attribute too much passivity and too much hostility to weak people. This suggests that an unusually intense contemptuous superior attitude may exist in relation to weakness in others.

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22

Adjustment Through Aggression: The Sadistic Personality

The next sector of the diagnostic continuum is the area of critical hostile aggression. We shall consider in this chapter those human beings who manifest in their overt operations cold sternness, punitiveness, or sadism. This is the "33" personality.

This way of life is traditionally one of the most fascinating and disturbing. We are dealing here with the fearful and destructive aspects of human behavior. We shall attempt to understand why some individuals select negative, hostile expressions as their means of adjustment.

Philosophers and psychologists have for centuries recognized that many human beings are compulsively committed to aggression. Many theories have been advanced to explain why some persons delight in combat, feel comfortable only when engaged in a threatening attack, experience no qualms at punishing their fellows, and, indeed, feel weakened and threatened by the prospect of collaborative or tender or docile impulses.

An important point must be introduced at this early stage of the discussion. We are referring in this chapter not just to actions of criminal aggression, destructive violence, or socially disapproved sadism. We include all those behaviors which inspire fear in others, which threaten others by physical, moral, or verbal means.

Many antisocial individuals utilize this hostile mode of adjustment. But the great majority of punitive sadistic characters are to be found in the ranks of the socially approved. Those persons who consistently maintain a punishing attitude towards others, or a disciplinary attitude, or a sarcastic attitude, or a guilt-provoking attitude fall in this diagnostic category. Stern toughness is frequently admired and endorsed as a positive social adjustment.

Those individuals who become repetitiously engaged in physical violence would, of course, be given the interpersonal diagnosis of aggressive personality. But a large percentage of the cases falling in this diagnostic category do not go around punching others—they communicate their critical, hostile messages in more subtle, but equally effective means. We think here, for example, of the stern unforgiving father, the bad-tempered wife, the moralistic guilt-provoking mother, the sharp-tongued mocking husband, the grim-faced punitive official, the truculent fiery-natured colleague, the disciplinarian. We include all those law-abiding, often pious and self-righteous, individuals who maintain a role of potential insult, derogation, or punishment.

As we shall see in the subsequent sections, this mode of adjustment is far from being limited to the delinquent margins of society. It appears with frightening regularity in the ruling groups of most societies —present and past—expressed in the philosophy of repressive legislation and bellicose foreign policies.

In the next few pages we shall propose some speculations about the purpose, the effect, the survival advantages and disadvantages of aggressive security operations.

The Purpose of "33" Behavior

Those individuals who are overtly hostile and punitive have selected these behaviors because they sense them to be the most effective in minimizing anxiety. These interpersonal reflexes communicate a message of hardboiled toughness: "I am a dangerous, fearful person." The persons who rely on these operations for their emotional security are least anxious when they are flexing their muscles or expressing stern coldness. They are made most anxious in a situation which pulls for tender, agreeable, or docile feelings.

These individuals have developed their involuntary interpersonal reflexes because they have learned consciously or unwittingly that this is, for them, the safest mode of adjustment. When they are acting tough or stern, they feel protected. When they act unaggressive, they feel unprotected and painfully uncomfortable.

Sadistic, tough human beings apparently find security and pleasure in acting hardboiled; their self-respect seems to stem from the provocation of fear in others. Hurtful, mocking, destroying, threatening actions endow the actor with a fearful power. The threat of a temper outburst or a savage attack is a forceful weapon for coercing and managing others. Even the less violent aspects of this interpersonal operation—critical, disciplinary behavior—carry an authoritative social weight.

Hostile, critical conduct is generally viewed as negative and ethically lamentable. Despite this moral censure this deportment is accompanied by feelings of righteousness. The most bitter delinquent, as well as the most punitive disciplinarian, often justifies his transactions by pious reasons. Sadists thus do not always feel the pain of guilt or the whip of social disapproval. In fact they often fit themselves into contexts where harshness and coercion are admired or accepted. The aggressive criminal gains respect in his own society. The martinet wins esteem within his own sphere of activities. The common genus of household sadist usually operates in reciprocal relationship to masochistic marital partners, who respond submissively.

Another very important purpose of punitive or critical behavior is the provocation of guilt. The generic function of the hostile way of life is to destroy, to humiliate, to cow the "other one." This can be done violently. It can also be done indirectly. The cold, stern, disapproving attitude has the aim of making the "other one" feel either inferior or unworthy. The sense of righteousness and austere punitiveness is a most common and forceful attitude. Moral coercion is a most effective and self-satisfying form of sadism since it allows the release of destructive, hostile feelings along with the comforting support of self-approval.

The Effect of "33" Behavior

We have seen that stern, hostile interpersonal reflexes serve several important purposes. They can reduce anxiety and the feeling of defenselessness. They express a feeling of armed protection, righteous irritation, and physical or moral superiority and force.

This powerful social maneuver has quite a consistent effect on other people in general and certain rebellious or masochistic people in particular. We shall consider first the general case.

Sadistic-critical behavior pulls resentment, distrust, fear, and guilt from "others." In systematic language *DE* provokes *FGH*.

The punitive, hostile role is a most effective interpersonal instrument. In the basic sense everyone fears destruction. Physical danger is, of course, the most crude and direct threat to any living organism. Social danger is, for the human being, a most fearful menace. This is expressed generically as disapproval or derogation. Almost everyone dreads and resents criticism and hostile laughter from others.[1]

Hostile coerciveness thus exerts a tremendous interpersonal leverage. It gains a fearful respect or a resentful submission. Moral deroga-

[1] An exception to this generalization is furnished by the overt masochistic character, cf. the discussion of the hostility-provoking buffoon in Chapter 16.

tion provokes guilt, and thus possesses a ruling force which can equal or surpass the threat of physical violence.

In the moderate form, the critical role yields advantages to both the actor and the "other." No institution exists which does not depend to a certain extent upon social disapproval as a cementing and centrifugal agent. The stern, judicial, punitive person thus becomes a human symbol of the rules and sanctions which exist either explicitly or implicitly. The critic or disciplinarian serves a healthy function in the economy of the group and gains respect and security for himself. Flexibility and adaptive moderation again become the criteria which differentiate the adjustive from the maladjustive.

In many families one of the parents generally pre-empts this role, and thus gains the fearful respect and gives the reassurances of limits to the others. The well-adjusted aggressive-punitive person does not rely on these interpersonal reflexes rigidly. He can shift to other behaviors when they are appropriate and when the critical functioning is not called for.

In the extreme form, the sadistic role becomes the nucleus of complex neurotic phenomena. The maladjusted aggressive person is the one who manifests this operation inflexibly and to an intense degree. He operates as though anxiety is associated with the relaxing of toughness and this anxiety he cannot tolerate.

Extreme or consistent sadism has a most electrifying effect on the "other one." Most people are made uncomfortable and ill at ease in the presence of an explosive or condemnatory or sarcastic person. They tend to fear him and to avoid him when possible.

Most individuals can tolerate, and even appreciate, the function of an adjusted critic. They cannot tolerate potential or actual hostile coercion in others. This is to say that when extreme *D* behavior pulls adaptive withdrawal and bitter disaffiliation from "others," the interaction terminates.

There are two general occasions when this pattern does not hold: in the case of the reciprocal sado-masochistic relationship and in the crime-punishment partnership. There exists a large number of individuals who are most comfortable (although not necessarily happy) when they are tied to a hostile partner. A most common variety of this is found in the masochists. An intense symbiotic relationship exists between those who are least anxious when hurting or derogating and those who are least anxious when receiving these negative actions. In this case *DE* pulls intense maladaptive and rigid *GH*.

Elaborate multilevel patterns exist in the sado-masochistic relationship. A maladaptive rigid sadistic façade usually covers underlying feelings of fear and weakness. These are neutralized by the comfort-

ing protection of hardboiled operations. The overt hostility in turn breeds guilt and a fear of retaliation which leads to an intensification of the original reflex. Similarly the overt masochist inevitably possesses "preconscious" sadistic identifications. The masochist provokes hostility from the "other" which is generally followed by the provocation of guilt in the aggressor. The anxiety associated with this hostile or righteous maneuver usually results in a resumption of the masochistic operations.

The multilevel interactions of couples who are involved in sadomasochistic locks is one of the most interesting and complex human relationships. The delicate interaction between the two forms of sadism—physical and moral—are nicely illustrated in these not atypical cases.

A second familiar symbiotic relationship exists in the intense reciprocal partnerships between rebels and punitive authorities, between criminals and the agents of punishment. It is well known that irrationally unconventional and antisocial individuals pull hostility from others (cf. Chapter 15). The alienated schizophrenic, by means of his purposive eccentricity, provokes society to incarcerate him. The rebellious student trains his teachers to discipline him. The professional radical eagerly searches his atmosphere for evidence of repressive cruelty (e.g., racial discrimination) and often succeeds, not in helping his cause, but in gaining the condemnation of others. Brilliant creativity often reaches its peak in reaction to hostile, unsympathetic, restrictive regulations. The other (punitive) side of this crime-punishment partnership works with equal purposiveness. Hostile punitive people seek out rebellious and distrustful others and integrate durable relationships with them. Policemen look for crime. The disapproving moral sadist looks for sinners. The bully feels most comfortable in receiving the resentful reactions of those he coerces.

Remarkably intense and lasting relationships develop between antisocial rebels and the punitive figures whose anger they attempt to provoke. The recidivist criminal is least anxious when he is dealing with the comforting consistency of prison custody. The punitive person is most comfortable when he has targets for his hostility. The severely maladjusted sadist thus gravitates towards bitter, guilty, and fearful "others."

Clinical Manifestations of the "33" Personality

The sadistic type may be known by his symptoms. These patients do not manifest the depressive characteristics of schizoids, obsessives, and phobics. They are not loaded with worries. They do not complain of physical symptoms.

They come to the clinic usually under the pressure of unsatisfactory interpersonal relationships. Marital problems are very common. Discord and friction in their jobs frequently are mentioned. Often they are in trouble caused by their hostility. In these respects they appear much like the rebellious schizoid patients. Both diagnostic groups emphasize negative, angry interpersonal reflexes. The schizoids are passively hostile, while the sadists are actively hostile. The schizoids are mad and sad; the sadists are mad and not sad. They are less concerned with their problems. As they describe their life events, a note of contempt and disgust with others often develops. It becomes clear that they are giving others in their life a bad time, that they are looking down contemptuously upon others.

These patients often express unconventional ideas and admit to unconventional feelings. They may, in fact, make a point of avoiding conventional feelings and ideas, and when they do employ them they are often used to derogate others. A sadistic wife may, for example, admit to aggressiveness in herself and then criticize her husband for not being easygoing. A punitive man may admit his own sexual adventures with a certain hardboiled, sophisticated justification and wax indignant at the misconduct of others.

In their demeanor during diagnostic interviews these patients generally manifest aggressiveness coupled with some other interpersonal role. This is due to the fact that pure, unconflicted aggressive characters rarely come to a psychiatric clinic. Invariably the aggressive patient presents a conflicted façade. His blunt, tough security operations have led to trouble, or else he would not be visiting the clinic. Many aggressive patients have intense covert feelings of weakness or guilt. These may be apparent in the clinical interview. The brutal husband may express verbal guilt for beating his wife or children. The aggressive woman may verbalize pious conventional feelings in the effort to prove how contemptible her husband has become. The guilt in the first case and the bland conventionality in the latter will be seen to be superficial and verbal. These patients may sound guilty but they are not depressed. They may sound cooperative and agreeable but their contemptuous attitudes will be picked up by the Level I symptomatic tests (MMPI) or by the alert interviewer. These feelings often appear in the form of sarcastic or depreciatory references to psychiatry or psychotherapy.

It has been pointed out that "33" characters come to the clinic complaining of interpersonal problems rather than anxiety symptoms. There are certain specific familial situations which are typical of this personality type. The blunt, active, righteous, angry wife of the delinquent husband is one such case. These patients often calmly

describe a long history of marital turmoil in which a weak, immature spouse repeatedly offends the punitive wife with chronic alcoholism, gambling, unemployment, etc. The wife often supports the family and rules the spouse with a guilt-provoking disciplinary coldness to which the husband reacts with alternating guilt and rebellion. These partnerships often are of long standing. The punitive member comes to the psychiatric clinic in the wake of a current episode of interrupted rebellion on the part of the spouse. The motive in coming may be to seek help in dealing with the husband, rather than help in changing her own behavior. The feeling of righteous indignation communicated becomes diagnostic. Inevitably testing reveals that masochistic trends underly these stern, punitive overt operations. "Preconscious" guilt and self-punishment picked up by fantasy tests often indicate that the patient is close to recognition of the underlying feelings of weakness, and these may provide the push which causes the patient to come to and stay in therapy. Another typical complaint of the aggressive character involves disgust or concern over symptoms in children. Delinquency, bed-wetting, and phobias often characterize the offspring of these patients.

A third reason for coming to the clinic concerns authority problems. The aggressive person often finds himself in a jam and comes for help under the pressure of disciplinary actions. These frictions are usually due to overharshness with subordinates, quarrels with equals, or insult to a superior. These patients do not manifest real guilt or unhappiness about these interpersonal conflicts, and they make it clear that the fault lies in the "other one."

There are psychometric signs diagnostic of the stern or sadistic personality. Their MMPI profiles emphasize peaks on the hypermania, psychopathic deviate, and F scales. The Sc score is usually higher than Pt. The depression score is not pronounced. The Mf (femininity score) is usually low for male patients and varies for female patients depending on the amount of underlying masochism or passivity.

Interpersonal Definition of the Psychopathic Maladjustment

Evidence has been presented (cf. Chapter 12) that certain interpersonal maladjustive types were related to psychometric diagnostic categories.

Hostile, sadistic security operations are characteristic of the psychopathic personality. The essence of the psychopathic state is active aggression. These patients avoid anxiety and maintain security by avoiding dependent or tender feelings and by integrating critical, punitive relations with others.

The classic generalization that psychopaths cannot love fits the logic of the circular diagnostic continuum since the *DE* octant which defines the psychopath is exactly opposite the affiliative sector of the circle.

Again it must be stressed that we are employing a definition of the kind and degree of abnormality which is based on personal, and not cultural, values. The cultural definition of the psychopathic maladjustment stresses the inability to conform to social norms. This is a poor definition because schizoid characters (as defined by the interpersonal system) seem to get into trouble as frequently as psychopaths. We have already stressed the point that many sadistic individuals are quite acceptant of punitive and repressive ethical values. The psychopathic personality in the interpersonal system is defined by the aforementioned typical security operations and not by delinquency. As a matter of fact, sadistic people are perhaps more often unusually identified with law and moral codes which they ruthlessly employ to humiliate others. The more a person goes out of his way to claim an ethical superiority and to attribute immorality to others, the greater the probability that he manifests psychopathic, morally sadistic operations.

The distrustful schizoid patient is acutely aware of moral hypocrisy in others. Some psychopaths often show a radar-like sensitivity to rebelliousness and guilt or weakness in the "other one."

Research Findings Characteristic of the Sadistic Personality

Some of the current research findings which concern the aggressive personality can now be considered.

1. Patients who manifest stern aggressiveness in their overt operations do not have psychosomatic symptoms.

2. Psychosomatic patients do not utilize these interpersonal operations at Levels I and II.

3. Aggression at Levels I and II is related to high MMPI scores on nonconformity (F), schizoid distrust (Sc), and disidentification with affiliative values (Pd).

4. If sadistic patients enter psychotherapy, they tend to remain in treatment for long periods. They stay in therapy as long as any other diagnostic type. Severely conflicted psychopaths (i.e., large discrepancies between Level I and II) are, however, poorly motivated for treatment, remaining on the average for only two sessions. This indicates that the psychopath like the phobic presents a tricky prognostic gamble. They either avoid therapy entirely or they enter and remain for extended periods. Multilevel conflicts can lead both of these groups to avoid intensive treatment. Schizoid and obsessive

patients on the contrary are more likely to stick in treatment regardless of the degree and kind of multilevel conflict.

5. The psychopaths, like the schizoids, are the most disidentified (consciously) with their parents.

6. They tend as a group to be consciously disidentified with their marital partners.

7. They (along with the schizoid group) tend to misperceive the interpersonal behavior of others. They inaccurately attribute too much hostility to others.

8. Patients who manifest aggressiveness in their Level I-M symptomatic behavior tend to appear in certain cultural samples much more frequently than others. The percentage of sadistic persons in various samples is presented in Table 30.

TABLE 30

PERCENTAGE OF AGGRESSIVE-SADISTIC PERSONALITIES (LEVEL I-M) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Aggressive-Sadistic Personalities*
Psychiatric Clinic Admission	537	11
College Undergraduates	415	3
University Psychiatric Clinic	133	11
Middle Class Obese Patients (Female)	121	4
Overtly Neurotic Dermatitis Patients	31	10
Self-Inflicted Dermatitis Patients	57	2
Unanxious Dermatitis Patients	71	3
Group Psychotherapy Patients	109	7
Individual Psychotherapy Patients	49	6
Hypertensive Patients	49	2
Ulcer Patients	43	8
Medical Control Patients	37	0
University Counseling Center	93	2
University Graduate Students (Male)	39	0
Stockade Prisoners (Male)	52	15
Hospitalized Psychotic Patients	28	11
Officers in Military Service	39	0
Total	1903	

As might be expected, the stockade prison group contains the largest percentage of psychopathic individuals. The psychiatric clinic samples include about the number expected by chance. All the other samples have a negligible number of this personality type.

It is of interest to note the discrepancy between psychopathic personalities reporting to the clinic and those going into group or individual psychotherapy. Only half the expected percentage of sadistic individuals go into treatment. This indicates that either those patients tend to avoid going into therapy or the clinic refrains from re-

ferring them to therapy. They come to the clinic in the expected frequency but their reasons for coming (which often involves blaming others) do not lead them to go into therapy. Once they do enter treatment, they tend to stay a relatively long time. This means that sadistic patients are poorly motivated but have long prognosis for treatment.

9. The percentage of sadistic personalities at Level II-C is presented in Table 31. Ulcer patients claim the most aggressiveness. Normal controls and psychiatric clinic admissions attribute more sadism to themselves than expected by chance. The hypertensive and obese samples (who stress hypernormal strength) have considerably fewer self-diagnoses in the aggressive-sadistic octant.

TABLE 31

PERCENTAGE OF AGGRESSIVE-SADISTIC PERSONALITIES (LEVEL II-C) FOUND IN SEVERAL CULTURAL SAMPLES

Institutional or Symptomatic Sample	*N*	*% of Aggressive-Sadistic Personalities*
Psychiatric Clinic Admissions	207	18
Hospitalized Psychotic Patients (Male)	46	11
Group Psychotherapy Patients	101	11
Individual Psychotherapy Patients	38	8
Overtly Neurotic Dermatitis Patients	31	10
Self-Inflicted Dermatitis Patients	56	14
Unanxious Dermatitis Patients	70	11
Medical Control Patients	41	17
Ulcer Patients	42	24
Hypertensive Patients	49	4
Middle Class Obese Patients (Female)	100	4
Total	781	

10. Sadistic patients describe their parents as weaker and more neurotic than any other diagnostic group. They clearly look down on their parents—seeing them as beaten, impotent, timid, unsuccessful, and unloving people.

11. Sadistic patients describe their spouses as rebellious and resentful people. This indicates that their marital relations are loaded with punitive affect. They are stern and disapproving in relation to resentful, passively resistant spouses.

V

Some Applications of the Interpersonal System

Introduction

The aim of the Kaiser Foundation research has been to develop a system of personality which is functionally useful in the psychiatric clinic. The norms have been based on clinic samples. The empirical investigations have attempted to build up probability statistics which allow us to predict what the patient will do in the clinic setting.

The system has, for the first six years of research, been deliberately restricted for the most part to that narrow range of interpersonal behavior which is relevant at the time of intake evaluation and planning for psychotherapy. The major application of the system is to problems of diagnosis and prognosis faced in the psychiatric clinic.

While the main focus has been on clinical diagnosis, there have been some side explorations to determine the efficacy of the interpersonal system in predicting behavior outside of the psychiatric clinic.

In the next four chapters we shall report on some applications of the interpersonal system in these nonclinical situations.

Chapter 23 will report on the use of these diagnostic methods in a psychiatric hospital. The interpersonal pressures faced by the staff of an inpatient service are clearly different from the outpatient facility. Our experience in using the interpersonal methodology in this situation is very limited. The results of our pilot study are strikingly different from the outpatient studies and are partially confirmed, moreover, by our measurements on outpatients who have had psychotic breaks and required hospitalization. Some suggestions and implications concerning the application of interpersonal diagnosis in the psychiatric hospital will be tentatively advanced.

Chapter 24 takes us to a different environmental setting—the physician's office. We shall study the application of the system to psychosomatic problems faced by the internist and the dermatologist. Four samples of patients manifesting symptoms which are sometimes believed to be psychosomatic have been studied by the Kaiser Foundation research. The diagnostic system suggests that there are some personality correlates of psychosomatic conditions. The results of these studies and their clinical implications for the physician will be reviewed.

Chapter 25 describes some interpersonal dynamic factors observed in administrative, discussion, and management groups. The interpersonal measurement methods are easily converted into sociometric instruments. Patterns of reciprocal interpersonal relations and misperceptions of self and others are measured by very straightforward techniques. They provide a direct method for diagnosing an industrial management group and outlining the network of dynamic activities which occur in the group situation.

In Chapter 26 this survey of the application of the diagnostic system concludes with a consideration of interpersonal dynamics as they occur in group therapy. Methods for predicting and measuring *group resistance* and *group personality* will be described. This chapter also discusses the complex issue of multilevel interaction patterns as they evolve in group psychotherapy.

23

Interpersonal Diagnosis of Hospitalized Psychotics

The emotional atmosphere in any psychiatric hospital is inevitably different from that of the outpatient clinic. Implicit interpersonal forces are at play which affect the patient's behavior. One task of a diagnostic system employed in the hospital setting is to measure the patient's reactions to the social pressures of the hospital environment. The standard questions to be answered by a multilevel measurement apparatus are: What overt social role is the patient attempting to maintain (i.e., what are his interpersonal security operations)? How does he diagnose himself? What are his underlying feelings?

The interpersonal diagnostic system has been used in some limited, exploratory studies in a hospital setting. Some of the results will be reported in this chapter. These findings are preliminary and suggestive. They do contain several implications about the use of personality tests in the hospital and about the nature of the psychotic state.

Factors Unique to the Psychiatric Hospital

In assessing the interpersonal behavior of hospitalized patients it is clear that certain factors peculiar to institutional commitment are involved. The patients are certainly involved in a different relationship with the therapist than are patients in the outpatient clinic. The latter come mainly on their own volition. The clinic does not play such a vital 24-hour-a-day role in their lives. The outpatient is much more free to sever his relationship with the clinic.

The hospitalized patient is inextricably caught in a web of interpersonal assumptions which affect his behavior and his conception of self. He is legally committed; he has been rejected by society, and often by his family. He is not as free to govern his actions. He is dependent on the institution for sustenance, both material and emotional.

The interpretation of test results must take into account the emotional context of the hospital scene. We can never be sure how much the patient's behavior is directed towards the therapist-as-therapist and how much it is determined by his attitudes and interpersonal purposes towards the custodial institution and the rejecting outer world to which the hospital is related.

There is another factor which limits the application of the interpersonal system to hospital diagnosis. The system was developed to meet the needs of patients in a clinic. It is geared to patients who are of average intelligence and who are able to manage their affairs by themselves. Individuals who are severely psychotic (i.e., out of touch with reality, which usually means wildly rebellious against conventional standards) may not be able to meet the intellectual demands of our check lists and questionnaires.

For this reason we are very cautious in recommending the interpersonal system for general use in the psychiatric hospital. For many patients it seems to work with adequate success—that is, it successfully answers the question: what are the patient's interpersonal actions, beliefs, and underlying feelings?

The Psychotic Samples

Three samples of psychotic patients were studied by the interpersonal diagnostic system.

The *State Hospital Sample* [1] comprises 100 patients tested at Level I-M and 6 patients who were referred for group psychotherapy and were administered the multilevel interpersonal test battery before beginning treatment. The 100 patients were a random sample of patients who received the MMPI during diagnostic work-ups.

The criteria for selecting the six other patients were as follows: Seven patients were assigned to the therapy group. Six of them took the tests and received interpersonal diagnoses. The seventh patient was too disturbed to respond to the testing situation. All group members came from the same unit, a convalescent cottage. Five had received diagnoses of schizophrenia; one was diagnosed as a depressive psychotic. None were currently receiving any somatic treatment. The cottage is a semi-open ward and does not contain acutely disturbed patients. While the rate of discharge of patients in this unit is relatively high, patients selected for this therapy group were not expected to be leaving the hospital within the next four months.

[1] The sample of six hospitalized patients was collected by Richard V. Wolton of the Stockton State Hospital, Stockton, California. Gratitude is expressed to Mr. Wolton for his cooperation in administering the tests and for writing the clinical summaries included in this chapter.

A second sample of hospitalized patients has been studied by the interpersonal diagnostic system. These comprise patients who were evaluated in an outpatient clinic, diagnosed either as *psychotic* or *anxiety-panic* types and then hospitalized. This group of patients is called the *Clinic Psychotic Sample.*

There are 22 subjects in this "panic-psychotic" sample, 4 men and 18 women. Only 13 of these patients completed the tests at all three levels so that the *N*'s vary from level to level.

The *Private Hospital Sample* includes 20 patients who were in psychotherapy at the Pinel Foundation Hospital, Seattle, Washington.[2] There are obvious cultural and clinical factors which might differentiate private hospital patients from those seen in a state hospital or a health-plan clinic, but all three samples share the common experience of having been institutionalized because of this emotional symptom.

Level I Behavior in the Three Psychotic Samples

Level I-M scores are available for the state hospital and clinic psychotic sample. Level I-S ratings of each patient by professional observers (pooled ratings of doctors, nurses, and therapist) are available for the private hospital sample. Table 32 presents the number of patients falling in each diagnostic category at Level I.

TABLE 32

LEVEL I DIAGNOSES ASSIGNED TO 148 PATIENTS IN THE THREE PSYCHOTIC SAMPLES

Sample	N	Level I Diagnosis								Strong Loving 1678	Hostile Bitter 2345
		1	2	3	4	5	6	7	8		
State Hospital Sample .	106	22	17	15	6	6	10	6	24	60	46
Clinic Sample	22	2	2	3	4	3	3	1	4	10	12
Private Hospital Sample *	20	1	2	3	0	5	7	2	0	10	10
Total Sample	148	25	21	21	10	14	20	9	28	80	68

* The figures presented for the private hospital sample are based on Level I-S (raters' sociometric checks). The other two samples were studied at Level I-M—the symptomatic level.

No clear-cut trend is evident in these results. The findings suggest that hospitalized patients present a mixed picture at the symptomatic or overt interpersonal level. When the diagnostic continuum

[2] Gratitude is expressed to the administration of the Pinel Foundation Hospital and to Dr. Arthur Kobler of the Pinel Staff for permission to use the results obtained in their diagnostic studies.

is summarized in terms of positive conventional types (1678) as compared with hostile alienated types (2345), there are slightly more psychotic patients in the former category. In light of the nature of this sample this becomes a most interesting result. More than half of these patients who have been rejected by society and institutionalized for emotional disturbance present themselves as responsible, hypernormal, or conforming people. The implication is that many psychotics strive to maintain a Level I façade of conventionality and conformity.

The findings listed in Table 32 tend to duplicate the census of patients in the Kaiser Foundation outpatient clinic. These results suggest that the interpersonal pressure of the symptoms of psychotic patients does not differ from that manifested by the average outpatient visitor, and (as we shall see in the next chapter) the Level I façade of psychotics is significantly more hypernormal than that of outpatients who go into psychotherapy.

Level II-C Behavior in Three Psychotic Samples

The Level II-C self-diagnoses of the hospitalized patients which are presented in Table 33 present an even more interesting pattern.

TABLE 33

LEVEL II-C DIAGNOSES OF 46 PATIENTS IN THE THREE PSYCHOTIC SAMPLES

Sample	N	Level II-C Diagnosis								Strong Loving 1678	Hostile Bitter 2345
		1	2	3	4	5	6	7	8		
State Hospital Sample ..	6	2	3	0	0	0	1	0	0	3	3
Clinic Sample	20	2	1	3	4	2	2	3	3	10	10
Private Hospital Sample .	20	4	1	2	1	1	6	1	4	15	5
Total Sample	46	8	5	5	5	3	9	4	7	28	18

There is a definite tendency for institutionalized patients to see themselves as sweet, hypernormal, executive individuals! They tend as a group to deny hostile or weak traits. This strongly suggests that many psychotics cling to a conscious self-perception of strength, responsibility, and conventionality. They are significantly less alienated and guilty (at Level II-C) than outpatients in psychotherapy.

Level III-T Behavior in Three Psychotic Samples

The TAT "hero" indices were calculated for 38 patients in these studies and then plotted on the diagnostic grid. Table 34 presents the Level III-T diagnoses for the three samples.

TABLE 34

LEVEL III-T DIAGNOSES OF 38 PATIENTS IN THE THREE PSYCHOTIC SAMPLES

Sample	N	Level III-T Diagnosis								Strong Loving 1678	Hostile Bitter 2345
		1	2	3	4	5	6	7	8		
State Hospital Sample ..	20	0	0	2	0	1	2	0	1	3	3
Clinic Sample	6	3	0	2	3	1	0	2	1	6	6
Private Hospital Sample .	12	3	3	5	3	2	2	0	2	7	13
Total Sample	38	6	3	9	6	4	4	2	4	16	22

At the "preconscious" level these patients manifest interpersonal themes which are somewhat different from their overt and conscious presentations. Sadistic themes are the most common; power and distrust are the two next most frequent. Whereas the psychotics were significantly more bland and hypernormal than psychotherapy outpatients in conscious self-description, in fantasy they are significantly more hostile.

Multilevel Personality Patterns of the Hospitalized Samples

It is now possible to weave together the results from the three levels of personality and to make multilevel summary statements.

At the symptomatic level (Level I-M) the psychotics equal psychiatric clinic outpatients in the presentation of symptoms. At the level of conscious self-diagnosis a larger percentage of psychotics claim strength and conventional normality than do outpatients. At the level of "preconscious" fantasy, however, the psychotics are more bitter and hostile than the outpatients.

These data have suggested the following hypothesis. Many psychotics show highly conflicted personality patterns. Their overt security operations emphasize strength and normality, while their underlying feelings involve sadism and bitterness. Many psychotics cling desperately to a conscious façade of conventionality and self-confidence in the teeth of their underlying feelings of rage and frustration.

The presenting operations of many neurotics, on the contrary, stress overt passivity and bitterness, while their underlying feelings involve stronger and more affiliative feelings.

The over-all impression obtained from these studies is that the process of hospitalization involves different factors. In looking over the multilevel diagnostic codes for the individual patients, it is apparent that many patients are institutionalized because they are immobilized

by anxiety, distrust, guilt, and helplessness at all three levels. These would be clinically labeled anxiety-panic states, schizoid conditions, psychotic conditions, or psychotic depressions. Another larger group of hospitalized patients try to maintain a façade of strength and to cover up intense underlying feelings of rage and bitterness. The former group probably includes suicidal risks, withdrawn and apathetic operations. The latter group are usually called paranoid. Different therapeutic implications exist for these two broad groups of institutionalized cases.

Implications of the Multilevel Patterns of Psychotic Patients

A multilevel system of personality throws into clear relief the conflicts which exist in a patient's character structure. We have just reviewed two sets of evidence suggesting that many psychotics and prepsychotics present a two-layer façade of strength and normality covering intense feelings of rage and despair. There are several implications.

The first concerns the therapeutic handling of psychotics. Most hospitalized patients are institutionalized because they have exhibited unconventional behavior which frightens or alienates others. They are seen by others as crazy, psychotic, disturbed.

Many of these patients, however, see themselves quite differently —they strive to present themselves as confident and responsible. It seems clear that anyone who attempts to establish constructive communication with this kind of psychotic must pay respect to the façade of normality. The overt operations must always be understood and classified before therapy can deal with underlying feelings. Patients (in the clinic or in the hospital) who present a façade of strength tend to be poorly motivated for psychotherapy—since treatment threatens their security operations. Extended and painstaking preliminary procedures (educational talks, discussions in which the therapist stays on the side of the ego) may be necessary to prepare such patients for conventional psychotherapy. If these are short-circuited and an attempt is made to plunge the patient into therapy a disastrous communication situation develops—in which the therapist acts as though the patient needs treatment and the patient thinks and acts on the premise that he does not.

This multilevel psychotic profile has implications for the use of psychological tests. Many psychologists have used Level I and II instruments in testing institutionalized psychotics and have been disappointed in finding that the patients appear normal. The allegation has been made that the MMPI is invalid because it often reveals psy-

chotics as having normal profiles. Much confusion and damage has been caused by researchers who have administered tests to patients with a unilevel point of view.

If test responses are viewed as interpersonal communications between the patient and the psychologist and if a multilevel approach is maintained, then the issue of validity becomes clarified. If a psychotic produces a low MMPI profile and describes himself on questionnaires as nonsymptomatic, this does not invalidate the tests. On the contrary, these results provide most useful information. They tell the tester that the patient is attempting to maintain a façade of normality, that he wants to be seen as healthy and nonneurotic. The conception of levels enters here. The sophisticated diagnostician will proceed to administer tests which tap other levels. He will compare the overt and conscious "normal" operations with Level I reports from observers that the patient acts hostile, or with Level III materials indicating that intense private feelings of distrust exist. The bland façade is seen to cover paranoid hostility or psychotic despair.

The same unilevel error has been made by research psychologists who have attempted to demonstrate that the TAT fantasy story test is invalid because it does not differentiate between neurotics and psychotics. It is very possible that a sample of psychotics will show no more hostility and weakness in their TAT stories than neurotics. If these investigators had gone on to collect measures at the overt levels, they would have been surprised to discover that more psychotics covered their fantasy behavior with a façade of normality than did neurotics. The comparison between any two clinical groups cannot be made at a single level of personality without confusion or incomplete results.

The multilevel pattern which we have found to characterize many psychotics has implications for evaluating outpatients for psychotherapy. Many patients are seen for intake evaluation in the Kaiser Foundation clinic who manifest the multilevel pattern of overt conventionality with underlying sadism or distrust. There are dozens of such multilevel diagnoses, e.g., 773, 884, 173, etc. This is a prepsychotic pattern. These patients, many of whom are presenting psychosomatic symptoms, are never assigned routinely to therapy or analysis. In many cases they are given the opportunity to "repress out" of therapy or are seen in supportive counseling. If a patient with a prepsychotic multilevel diagnosis is assigned to treatment, the therapist is warned to watch for signs of anxiety. The question is posed: can this patient tolerate conscious awareness of his underlying feelings? Reactions to the earliest interpretations should be observed to see if psychotic trends or "flights into health" are developing.

Case Illustrations of Six Psychotic Patients

In order to illustrate the use of the interpersonal diagnostic system in the psychiatric hospital, we shall now present the test results and clinical histories of the six patients from the state hospital sample.

In each illustration we shall consider first a brief case history and a description of the patient's behavior in the group. The interpersonal diagnostic report will follow. It will be possible to compare the test results with the way the patient behaved both outside the hospital and in his therapy group.

THE WANDERER: DIAGNOSIS 616[3]

(1) *Clinical Data.* This 42-year-old male patient was born in a rural Midwestern state. His history is one of marginal social adjustment, marked by many arrests for drunkenness, molesting children, vagrancy, and nomadism. He was committed to this hospital shortly after his arrival in the community by freight train. At the time of his hospitalization the patient heard voices directed by the church, felt that the cabin in which he resided was wired with microphones to find out his thoughts, felt that medicine was poisoned. He impressed the examining physician as "friendly but shy." The diagnosis advanced was schizophrenic reaction, paranoid type, in a constitutionally inadequate individual associated with chronic alcoholism. Electro-shock therapy was initiated shortly after the patient's admission to the hospital, and during this course of treatment the patient was involved in numerous "special incident" reports and as a consequence was frequently placed in seclusion and restraint. After twenty-four electro-shock treatments, the patient was transferred to an open ward where he had ground privileges. He was a member of the therapy group for four months. Four months after the group terminated the patient's paranoid symptoms returned, and he was transferred to a closed ward where a second series of electro-shock treatments was begun. After four such treatments there was a moderate improvement and electro-shock therapy was discontinued. At last report the patient was doing well and has had his ground privileges restored.

(2) *Group Behavior.* The patient missed a few of the early meetings of the group because of his inability to remember days of the week. He knew, for example, that meetings were held each Wednesday at 9:00 A.M., but did not know when it was Wednesday. The

[3] Certain changes in peripheral details have been made in these case histories in order to insure anonymity. An attempt to preserve the essential quality of the case history has been made. The descriptive titles for each patient were supplied by the clinician who conducted the psychotherapy group.

patient's speech, especially in early meetings, was circumstantial and rambling; his manner was vague, nebulous, and cloudy. He seemed uncertain of his identity and seemed to have very few resources in the way of stable and enduring personality characteristics. His adjustment appeared to be on a day to day and even on a minute to minute basis.

At about the seventh meeting of the group the patient began to change. He took a more active part in group discussions, no longer missed meetings, and displayed obvious interest in the responses and reactions of the others in the group. Although profoundly amnesic to many episodes in his past, the patient seemed to be trying to put the pieces together and re-establish and redefine his personality outlines. In early sessions the patient's verbal responses were characteristically platitudinous, while in later sessions his comments seemed honest, direct, and at times, poignant. When the group terminated, it was noted that while the patient was considerably improved, no change in his hospital status was recommended.

(3) *Interpersonal Diagnostic Report.* This patient at Level I-M presents as mildly depressed—somewhat despondent. He does not stress his symptoms, does not attempt to make an extremely sick or neurotic impression. He is diagnosed as a moderate phobic or dependent personality at this level. This seems to fit the clinician's impression of his "friendly but shy" approach.

In his conscious self-description he presents a mixed picture. He denies hostility. He admits to some passivity but also claims independence and strength. He is very close to his ego ideal—indicating that he is self-satisfied, pleased with his personality, and not motivated for psychotherapy.

His "preconscious" hero themes stress inordinate passivity and feelings of weakness.

The multilevel pattern thus reveals a strong, independent façade with some feelings of depression—and underlying feelings of helplessness. His basic feelings of despair and weakness are expressed indirectly in his symptoms but are not consciously recognized. These underlying feelings apparently did reach expression in the poignancy noted in later sessions of the group.

(4) *Clinical Implications.* (*a*) *Motivation.* This patient would not be considered as well-motivated because he is not under great symptomatic pressure (Level I-M = moderate *6*) and is self-satisfied (Level II-C = *1*).

(*b*) *Prognosis.* Prognosis is complicated by the underlying feelings of helplessness and dependence (Level III-T = 6). Male pa-

tients whose "preconscious" themes locate in this octant are more difficult to treat because therapy will lead to the expression of passive (and usually feminine) emotions.

(*c*) *Predicted interpersonal behavior.* The Level I-M and Level II-C measures tend to predict accurately to the platitudinous approach.

THE POIGNANT ROMANTIC: DIAGNOSIS 613

(1) *Clinical Data.* At the time of his admission to the hospital this patient was a 42-year-old white married male who spoke in an irrelevant, illogical manner much of the time. He showed many religious delusions and was depressed and agitated. The patient had been married for the past fourteen years, and throughout this period showed an abnormally strong attachment to his father. He has frequently expressed a desire to help his father at the expense of his wife and two children, who were often in dire financial straits. He would become violently angry if thwarted in his desire to aid his father, and on one occasion knocked out several of his wife's teeth when she expostulated with him. He frequently expressed ideas that he should make his living as a writer, although he has had nothing published. In the two months immediately prior to his commitment the patient became much more disturbed and confused. He would preach constantly and incoherently, stating that God had directly communicated with him.

The patient was given electro-shock therapy and made an immediate and favorable response to it. After six treatments the patient was much improved. He became a member of the therapy group, and after the group terminated the patient was given an indefinite leave of absence to his family. On subsequent examinations at the hospital the patient was described as "sullen and aggressive" by the examining physician, but there had been no relapse of sufficient degree to warrant hospitalization.

(2) *Group Behavior.* The patient's behavior in the group was characterized chiefly by his sober, earnest manner. He rarely smiled, and was by far the most reflective member of the group. From the beginning, the patient's contributions to the group discussion were relevant, pertinent, and coherent, with no evidence of the psychotic manifestations contained in the commitment report. The patient was quite self-punitive in presenting his problems to the others in the group. He described himself as a failure as a father, as a husband, as a person, as a writer. He had much to say about how he always felt he should be a writer; how he always admired the use of language

and, especially, "big words." On one occasion he brought a collection of his writings to the group. These were all written when the patient was in late adolescence, and the papers on which they were typed were crinkled and abused by age. In substance, they contained a very ponderous philosophy in poetic forms, reminiscent of the duller works of the Victorian period.

The patient revealed a concern for the problems of the others in the group. He was supportive to an indiscriminate degree, and seemed to be asking for support when he chastised himself as a failure before the others. Such support was not reciprocated by the other patients, however.

(3) *Interpersonal Diagnostic Report.* This patient presents at Level I-M a mildly depressed, essentially normal picture. (All MMPI scales are below 70.) He is definitely not attempting to impress others as a sick, nervous person. He is diagnosed at this level as a docile personality.

In his conscious self-descriptions he stresses strength and hypernormal responsibility. He is quite close to his ego ideal—indicating self-satisfaction and no awareness of any need to change his personality.

The top two levels thus indicate a normal, conventional self-conndent façade.

At the level of fantasy a different picture develops. Intense feelings of bitter distrust and aggressive power are expressed.

The three-level pattern involves two layers of normality (he is a strong man, mildly depressed) covering intense sadistic feelings.

When this multilevel pattern is compared with that of the preceding patient, we observe that they are quite similar in their façades (both *61*) but very different at Level III-T. The first patient expressed helpless fantasies, which we related to his poignancy. The second patient manifests bitter, angry feelings, which are reflected in the sadistic violence reported in his clinical history and, perhaps, in the fact that the group responded negatively to him.

Once again we see a common psychotic pattern of a frail façade of normality conflicting with underlying pathology.

(4) *Clinical Implications.* (*a*) *Motivation.* This patient would be considered unmotivated because of the symptom-free, self-satisfied façade.

(*b*) *Prognosis.* The prognosis is complicated because of the intense "preconscious" feelings of hostility. The conflict between a bland façade and underlying bitterness (*613*) is always a potentially explosive one and difficult to treat by psychotherapy.

(*c*) *Predicted interpersonal behavior.* The three-level diagnostic code predicts the earnestness, the pedantry, and the sullen outbursts. It does not pick up the masochistic self-derogation—unless this is interpreted as complaining hostility.

THE NICE GUY: DIAGNOSIS 665

(1) *Clinical Data.* The patient was committed at the age of thirty-three by his wife and his mother following a suicide attempt (sleeping pills). The patient had asked his wife to join him in a suicide pact and had expressed feelings of hopelessness and profound despair for the few weeks immediately preceding his hospitalization. The clinical decision was that his primary diagnosis was a reactive depression, but of such a severe nature that it approached psychotic manifestations. The patient adjusted quite well to the hospital milieu from the beginning. He was assigned to an open ward and worked days in the same type of work in which he was employed before hospitalization. No somatic therapy was deemed necessary or advisable. The patient entered the therapy group and remained in it for six sessions. Then he left the hospital without permission. The patient's elopement was sudden and unexpected, since he had always been reluctant to discuss being discharged from the hospital. The patient frequently stated that he was rather afraid to leave the hospital to return to a world in which all sorts of terrible things could happen to him. Since the patient's unauthorized departure, no word has been received by the hospital regarding him.

(2) *Group Behavior.* Until the time of his abrupt departure from the hospital the patient was an active participant in the therapy group. A quiet man by inclination, he was very attentive to topics of discussion, listening with alertness and active interest. He encouraged other patients to discuss their problems in the group setting, but found it difficult to lead the way by using his own case as an example, although this was his expressed intention. The patient was probably in a better state of mental health than any other group member, and his participation directly reflected this. When another patient would express delusional material, he would try to steer the conversation into more comfortable channels. He was well liked by the other members of the group, who would refer to him as a "nice guy." The patient was discussed more freely by the others following his elopement than he was during the period in which he was an active group member. Resentment against his blandness and manner of departure emerged, was discussed, and was related to the patient's attempts to control group discussions and keep them on a "polite" level.

(3) *Interpersonal Diagnostic Report.* This patient presents a passive, dependent picture at Level I-M. He is much more depressed, worried, and anxious than the two preceding patients; that is to say, he is much more neurotic at the symptomatic level.

His conscious self-perceptions center around weakness, docility, and agreeability. He tends to be hard on himself. He completely denies any strong, generous feelings (which were claimed by the two preceding "sicker" cases).

A two-layer façade of extreme passivity and docile helplessness is indicated.

The underlying tests emphasize weakness, guilt, and feelings of rebellious bitterness.

The over-all personality structure involves three layers of weakness. There is much less conflict than in the two preceding cases. This patient is much more like the chronic severe neurotic seen (interminably) in the outpatient clinic. He is definitely different from the rest of the group. He is the only patient of the six who diagnoses himself (at Level II-C) as weak and needing help. He is the only member who stresses neurotic symptoms—depression and anxiety. When we recall the therapist's statement that this patient was in a "better state of mental health than any other group member," it becomes clear that internalization and expression of anxiety is a salutary security operation—a protection against psychosis.

(4) *Clinical Implications.* (*a*) *Motivation.* This patient is well-motivated for psychotherapy. He experiences symptomatic pressure. He is dissatisfied with his personality (c.f. the self versus ideal discrepancy).

(*b*) *Prognosis.* A rigid and deep-seated commitment to passive, masochistic security operations (665) suggests a slow prognosis. This patient tends to avoid (at all levels) strong, responsible behavior. Negative identifications and underlying guilt will make therapy a very long-term proposition.

(*c*) *Predicted interpersonal behavior.* The top level scores (66) predict a docile, conforming, placating façade and an avoidance of hostile relations. They correlate with the clinician's impression of a "nice guy." The tests ignominiously fail to predict his going AWOL. We should expect masochistic self-effacement. The TAT does pick up some rebelliousness but does not forecast an active disaffiliation.

There is an interesting side issue which develops from this case history. This patient is the only member of the group who was not diagnosed as schizophrenic. He was given the label *severe reactive depression.* This patient manifests the "weakest" multilevel pattern.

He is the only patient in the group who is dependent or masochistic at all three levels (665), the only patient who does not claim or express strength at some level.

This patient was hospitalized not for psychotic symptoms, but for suicidal depression. No delusional or paranoid material was elicited.

This patient does not fit the multilevel pattern of the paranoid group of five patients who claim normality or self-confidence and repress hostility. He stands as the representative of a second multilevel type which is often seen in psychiatric hospitals—patients who are crippled and incapacitated by a solid three-layer structure of despair, helplessness, and masochism.

CYNIC AND TOUGH GUY: DIAGNOSIS 126

(1) *Clinical Data.* This 42-year-old patient was born in Texas, the youngest of fourteen children. He has resided in California since 1937, and his present hospitalization began in 1953. The patient was previously committed to this hospital in 1940, when he was diagnosed as schizophrenic reaction, simple type. He was discharged early in 1945 as "recovered," but was recommitted in 1953 upon the petition of his mother and siblings as: "confused . . . mumbles to himself . . . frightens neighbors . . . loud screaming . . . abusive." The patient was brought to the hospital with a black eye by police, who said that he had incurred it while resisting arrest. The patient has had many altercations with the law, usually occurring on occasions when he was intoxicated and/or driving. The patient has never married and disclaims any close attachments. In appearance he is lanky, dour, undernourished. Throughout his hospitalization the patient received no somatic or psychotherapy until becoming a member of the therapy group. In May, 1954, the patient was granted a town pass to get a job with leave-to-self recommended when he found employment. The patient would leave the grounds early in the morning and come back to the hospital to sleep. This continued until July, 1954, when the patient returned to the hospital in an intoxicated condition and abusive manner. He was transferred to a closed unit, where he currently receives electro-shock therapy.

(2) *Group Behavior.* The patient attended all the group therapy sessions and maintained a forthright and consistent position throughout their course, to wit, that he should not have been put in the hospital, that there was nothing whatever the matter with him, that hospitalization was more suitable to the needs of those members of his family who had him committed. The patient frequently stated that if

the state wanted to support him and provide him with an easy life he had no objections to such a program. He was an active member of the group, but formed no close attachments within it. He often scoffed at the remarks of the other group members, and on several occasions shocked the other patients by making casual and crude observations on sexual topics. His personality defenses seemed well-organized at all times, and he was able to maintain his equilibrium when pressured by other patients as to why he found it necessary to be such a "tough guy" at all times. The patient responded to this by saying that if feelings were put out in the open "somebody would stomp on them." This type of stomping was frequently demonstrated by him on the feelings of other group members. At the termination of the group self-leave was recommended, since he was functioning on a nonpsychotic level.

(3) *Interpersonal Diagnostic Report.* This patient at Level I-M manifests a strong, unworried front. There is no attempt to present as a sick person—neurotic symptoms are denied. His interpersonal diagnosis at this level is—autocratic personality.

The underlying tests reveal intense feelings of weakness, helplessness, and dependence.

A fierce conflict exists between overt toughness and "preconscious" passivity. He cannot tolerate awareness of his underlying fear and impotence. He attempts to maintain strong counterphobic operations.

This multilevel pattern (126) seems to fit the clinical picture. He was able to express in group therapy his need to be strong and his anxieties about being seen as weak. He apparently was willing to stay in a protected, dependent situation in the hospital (thus satisfying his underlying passivity), while stoutly maintaining the verbal picture of strength.

(4) *Clinical Implications.* (*a*) *Motivation.* This patient is not a candidate for psychotherapy. His counterphobic operations would be threatened by the implications of treatment. He has no conscious feelings of anxiety or depression. He is satisfied with his adjustment (no discrepancy between Level II-C and Level V-C).

(*b*) *Prognosis.* The therapeutic outlook for the 126 personality type is guarded. The conflict is intense, the façade is brittle (the underlying passivity does not leak through in the form of symptoms and is completely avoided at Level II-C). There is the additional factor that underlying passivity often leads to a poor prognosis. The patient is warding off feelings of impotence and, in many cases, feminine identification. Unless ego strength is pronounced (which is not the

case with this patient), recognition of the underlying feelings will be accompanied by intense anxiety.

(*c*) *Predicted interpersonal behavior.* The test pattern (12) predicts fairly well the therapist's descriptive title of "cynic and tough guy."

THE COMMENTATOR: DIAGNOSIS 228

(1) *Clinical Data.* This patient is a 35-year-old divorced white male who was committed from a county hospital. For about two weeks prior to commitment the patient complained of a dust which kept falling from the ceiling and choking him. He was told this was "psycho dust" by voices which he was unable to identify, except that he thought doctors might be attempting to treat him from "long distance." He was well oriented to time, place, and person. He displayed no gross personality disorganization. For this reason electroshock therapy was not selected as a proper treatment method, and psychotherapy was recommended. The patient was transferred to an open ward and became a member of the therapy group.

The patient was born in Alabama and resided in the southern region of the United States until he entered the army during World War II. Since his youth the patient has been a heavy drinker and was frequently arrested when intoxicated. On several occasions he experienced delirium tremens and was admitted to an Alabama state hospital until they subsided. He performed quite well in the armed forces and was a technical sergeant at the time of his discharge. Since leaving the service, the patient has adjusted on quite a marginal basis, shifting from job to job and town to town, drinking heavily and working as a seasonal unskilled laborer.

Following group therapy the patient was being considered for self-leave and eventual discharge when he was transferred to a Veterans Administration hospital.

(2) *Group Behavior.* The patient attended all group sessions, and although he never presented any problems of his own for group discussion, he was a very active participant. He speaks in a rather drawling Southern accent with a dry humor which was especially effective because of the apt sense of timing that he displayed. He was liked and respected by the other group members, who referred to him as "intelligent." He never put forth any facts about himself or any problems except for some very superficial facts regarding past education, vocational background, etc. His chief role in the group setting was

to act as a sort of commentator, interpreting the remarks of the others in a humorous and sometimes penetrating manner, reminiscent of Will Rogers. In private conversations with the psychotherapist the patient expressed some anxiety about being deported to a state hospital in Alabama where his family lived, but he did not discuss this or any other area of insecurity in the group. He offered general comments and advice to other patients in the group, but discouraged any inquiries that they might have regarding his own feelings.

(3) *Interpersonal Diagnostic Report.* This patient presents a very mixed picture at Level I-M. He feels depressed, worried, isolated, and alienated. He thus internalizes his problems and recognizes emotional symptomology. On the other hand, he tends to emphasize physical symptoms and bland activity. There is, moreover, some tendency to maintain a conventional denial of psychopathology. An intense ambivalence at this level is apparent. The tendencies to minimize emotions and to maintain strength are stronger than the admission of weakness. He is diagnosed at Level I-M as a narcissistic personality.

In his self-perception he presents himself as normal and self-confident. His diagnosis at Level II-C is competitive personality.

His underlying tests are also conflicted, expressing strength and conformity.

The indices from all five interpersonal tests administered to this patient fall in a narrow sector of the diagnostic grid—reflecting self-confidence and strength. There is some emotional symptomology, but this is minimized by the effort (apparent at Levels II and III) to act as a conventional, executive person.

(4) *Clinical Implications.* (*a*) *Motivation.* His overt security operations tend to make him an unmotivated patient. He sees himself as close to his ego ideal. He admits to some emotional symptomology but the repressive externalizing tendencies are considerably stronger. He denies wanting or needing help.

(*b*) *Prognosis.* This patient exerts a rigid control over his interpersonal behavior. Although he is riddled with symptoms and relegated by society to a psychiatric hospital, he still maintains a four-level structure of strength and conventional leadership. This rigidity may give him a certain stability and make it possible for him to function more adequately than the other group members—but the inflexibility means that any major change is not to be expected.

(*c*) *Predicted interpersonal behavior.* The solid multilevel commitment to self-confident, managerial operations (228) predicts accurately his role in the group.

THE AVENGER: DIAGNOSIS 123

(1) *Clinical Data.* This patient is a 41-year-old white male who was born in Nevada but lived most of his life in California, where he obtained a university degree in business administration. He then entered the employ of a major oil company and traveled extensively in its service. In 1941 while on foreign duty he attempted suicide and was returned to the United States but not hospitalized. In 1951 he was briefly hospitalized because of a schizophrenic episode. He responded rapidly to electro-shock therapy and insulin and was discharged.

At the time of his commitment the patient was married and the father of two children. He was extremely bitter about his hospitalization and very grandiose in his rationalizations. He was persecuted, drugged, perhaps poisoned, spied upon; the victim of greedy relatives and incompetent doctors. He made numerous threats and promises of revenge and retribution. Electro-shock therapy had no noticeable effect and was discontinued. The patient became a member of the therapy group when it was organized, but refused to continue after the second week. Shortly afterwards electro-shock therapy was resumed, and this time he showed improvement. He was transferred to the hospital annex, where his recovery progressed rapidly. He was described as a willing, cheerful, cooperative worker at the time of his release on indefinite leave of absence.

(2) *Group Behavior.* The patient came to the first meeting of the group and was by far its most active member. He assumed leadership of the group, questioned other patients, and steered the topics of conversation to world affairs such as A-bomb strategy, etc. The other patients in the group offered no overt objections to his taking charge, but the patient felt that the therapist should have asserted himself more than he did. During the second meeting of the group the patient announced that he was "resigning" from it. He gave as his reasons the incompetence of the therapist, the poor quality of the hospital staff, the fact that he had been receiving poisoned cigarettes, etc. The therapist encouraged him to remain in the group, but could only elicit from him a promise to defer his decision until the next week. The patient never came to any subsequent meeting, although he was told that he was welcome to do so.

(3) *Interpersonal Diagnostic Report.* This patient presents himself at Level I-M as a forceful, executive, active person completely free from any psychological symptoms. He does not want to be seen

as sick or isolated but, on the contrary, stresses his mental health and his conventional success. His diagnosis at this level is autocratic personality.

His self-perception duplicates almost exactly his symptomatic impact—although there is more emphasis on independence. His diagnosis at Level II-C is narcissistic personality.

His "preconscious" themes are loaded with superiority, rage, and bitterness. He is diagnosed at Level III-T as a sadistic personality.

(4) *Clinical Implications.* (*a*) *Motivation.* This patient is completely unmotivated for psychotherapy. He cannot stand any close or dependent relationships and maintains strong, defiant behavior at all levels. He is, of course, very self-satisfied and has no apparent desire to change himself.

(*b*) *Prognosis.* The test pattern predicts that he will not change. This disagrees with the clinical history which describes his cheerful cooperative recovery. This discrepancy may be a test miss. There is some possibility that his later conforming behavior is a deliberate repressive maneuver to obtain discharge.

(*c*) *Predicted interpersonal behavior.* The multilevel diagnosis (123) perfectly predicts the sequence of his behavior in the group—bossiness followed by an angry departure. It does not predict his recovery—but there is some possibility that he has temporarily and deliberately changed his tactics, not his personality structure.

24

Interpersonal Diagnosis in Medical Practice: Psychosomatic Personality Types

The interpersonal system of diagnosis has been developed and validated by an outpatient psychiatric clinic. In the last chapter we have reported some applications of the diagnostic systems in an inpatient setting—the psychiatric hospital. The locale of investigation now moves again—this time to the office of the medical practitioner. Are there typical multilevel personality patterns characteristic of the different psychosomatic conditions? If so, what are the functional implications of these personality factors? What do they mean to the internist who deals with these patients for treatment?

Several intensive empirical studies have been made which provide tentative answers to these questions. Several hundred psychosomatic patients have been diagnosed by the interpersonal system. The results indicate that the psychosomatic conditions investigated have typical personality correlates. The psychosomatic symptom groups with which we have been mainly concerned are: duodenal ulcer, essential hypertension, obesity, and dermatitis conditions (of unknown physical etiology). Samples of medical controls have been collected to compare with the psychosomatic groups. We have also followed the practice of comparing the behavior of psychosomatic patients with neurotic and psychotic patients and a psychiatric clinic admission sample. These studies have two purposes: (1) to throw light on the factors which differentiate among the four major symptom types: normals, psychosomatics, neurotics, and psychotics; (2) to test the validity of the interpersonal system, i.e., to see if the system differentiates these groups at the several levels of personality.

This chapter reviews the psychosomatic research which has been executed by the Kaiser Foundation project. At this point the results are far from definitive. They are being presented here not to *prove*

anything about the psychosomatic groups or to claim that psychosomatic patients can be diagnosed by means of personality tests. The study of any personality or symptom type is an enormously complex task involving multilevel patterns on large samples. In the case of psychosomatic groups, the external criteria themselves present taxing medical diagnostic problems.

The following studies are, therefore, an attempt to illustrate the interpersonal diagnostic system in action on research questions. The multilevel analysis clarifies certain issues and raises new hypotheses.

This chapter is outlined as follows: First, the ten samples are described; then, the behavior of each symptom group at Level I-M is presented and the results discussed; then, the same ten groups are compared at Level II-C. This is followed by the results at Level III-T. With the multilevel pattern of each group in hand, it will then be possible to present the typical personality structure and the nuclear conflicts of each of the ten important symptom groups.

The implications for medical and psychiatric handling of these cases will be included in these discussions.

Description of Samples

The ten symptom groups to be described in this chapter are:

Code	*N*	*Sample*[1]
U	41	1. Duodenal ulcer
H	49	2. Essential hypertension
O	98	3. Obesity
ND	31	4. Overtly neurotic dermatitis
SID	57	5. Self-inflicted dermatitis
UD	73	6. Unanxious dermatitis
C	38	7. Normals (medical controls who were not seeking help for emotional or psychosomatic symptoms)
N	67	8. Neurotics (in psychotherapy)
P	28	9. Psychotics (committed to state hospitals)
A	207	10. Random sample of psychiatric clinic admissions
	689	

The Duodenal Ulcer Sample[2]

There are 41 patients in the Duodenal Ulcer Sample. Of these, 32 are males and 9 females. These patients were referred from the gastrointestinal clinic by internists using these criteria: (1) positive X-ray diagnosis of either gastric or duodenal ulcer, (2) the absence of any

[1] These *N*'s refer to the total sample. The *N*'s for any level are slightly different because some patients failed to take tests at all three levels.

[2] The author is grateful to P. Raimondi, M.D., for providing the criteria and selecting the patients for the ulcer sample.

other explanation for the finding, and (3) typical pain-food-relief sequence of symptoms.

These patients had not requested a psychiatric referral; they were selected on the basis of their symptoms for research investigation. These selection factors must be taken into account. The fact that these patients were not involved in a psychiatric clinic referral may subtly influence their test responses. In all the findings reported below, it should be remembered that the ulcer sample was tested under circumstances different from the psychiatric clinic samples.

The Essential Hypertension Sample[3]

There are 49 hypertensive patients in this study. Of these, 27 are men and 22 women. These patients were referred from the cardiovascular clinic with the diagnosis of essential hypertension based on elaborate criteria being used for a simultaneous study of hypertensive diseases. In general, they are patients below the age of forty-five, with blood pressure consistently in excess of 145 mm Hg systolic and 90 mm Hg diastolic, who, by means of kidney function tests, ephinephrin neutralization tests, etc., were found to have no discernible cause for their elevated blood pressure.

The hypertensive patients were selected for a research study and were not self-referred for psychiatric evaluation. These selective factors may have influenced their attitude toward testing and therefore the findings should be interpreted with this possibility in mind.

The Obesity Sample[4]

The 98 female subjects who comprised the Obesity Sample were part of a large-scale study of obesity. The tests were administered before and after participation in discussion groups which lasted for about four months. These subjects were self-referred for weight reduction and did not come for a psychiatric evaluation. The fact that they were not seen in a psychiatric setting may have influenced their responses. The fact that the entire sample is comprised of women is another serious limitation. In all other samples studied, males are stronger (but not to a significant degree) at the façade levels than females. This factor should be taken into account when the data are considered.

[3] The author is grateful to A. A. Bolomey, M.D., for defining the criteria and selecting the patients for the hypertensive sample.

[4] The MMPI and interaction data for the obesity sample were taken from the Herrick Hospital Research Project on obesity. This research, supported by Public Health funds, has studied several factors—dietary, physiological, and psychological—which may be related to obesity. The psychological factors in the Herrick study have been investigated by Robert Suczek, Ph.D., whose theoretical and practical contributions to our work have been most valuable.

The Three Dermatitis Samples[5]

The dermatitis samples comprise 161 subjects of which 67 are males and 94 females. These patients were taken from the private practice of a dermatologist and were tested in his office by a secretary who was trained in the necessary psychometric methods.

The criterion used to select patients for the dermatitis sample was the presence of a skin symptom for which there exists no established physiological etiology. The specific symptomatic categories which made up the dermatitis sample were the following:

Acne	Hyperhidrotic eczema
Psoriasis	Alopecia areata
Seborrheic dermatitis	Urticaria
Atopic dermatitis	Acne rosacea
Eczematous dermatitis	Lupus erythematosus
Pruritis	Herpes simplex
Otitis externa	Warts
Neurotic excoriations	

This sample was selected under circumstances somewhat different from any other sample. Subtle additudinal factors may have partially determined the results; consequently, the findings should be considered with this caution in mind.

Examination of the multilevel patterns of the dermatitis patients revealed that considerable differences exist among the different symptomatic groups. For example, the acne sample presents differently at all levels from the pruritis sample. It seems clear that skin symptoms do not manifest one personality syndrome. The skin is, of course, mediated by a complex set of physiological systems and is, in addition, vulnerable to more external stimuli (e.g., self-inflicted excoriations) than any other organ system.

For these reasons it seemed advisable to divide the dermatitis sample into three relatively homogeneous subgroups. These are tentatively labeled the Overtly Neurotic Dermatitis Sample, the Self-Inflicted Dermatitis Sample, and the Unanxious Dermatitis Sample.

The symptomatic subgroups which comprise the Overtly Neurotic Dermatitis Sample are acne, psoriasis, and seborrheic dermatitis. The psychological characteristics defining this group are: anxiety and depression. The physiological criteria are not well defined, but there

[5] The dermatitis and neurodermatitis studies reported in this chapter are part of a large-scale study of emotional factors in dermatologic patients being conducted by Herbert Lawrence, M.D., Edward Weinshel, M.D., and the author. The criteria for defining these conditions were supplied and the selection of cases was accomplished by Dr. Lawrence.

seems to be a greater involvement of the sweat or oil apparatus. There are 31 patients in this subsample: 20 females and 11 males.

The Self-Inflicted Dermatitis Sample includes the following symptomatic subgroups: atopic dermatitis, eczematous dermatitis, pruritis, otitis externa, and neurotic excoriations. This group is characterized psychologically by less anxiety and depression and considerably more underlying sado-masochism than the Overtly Neurotic Sample. The dermatological criteria which define this group are vague but would include itching, scratching, and more self-inflicted damage to the skin. This subsample includes 57 patients: 33 females and 24 males.

The Unanxious Dermatitis Sample contains the following symptom groups: hyperhydrotic eczema, alopecia areata, urticaria, acne rosacea, lupus erythematous, herpes simplex, and warts. The subsample is characterized (psychologically) by a hypernormal façade with underlying sado-masochistic trends. The physiological criteria defining this group are quite vague but would include circulatory and virus factors. This sample contains 73 subjects: 41 females and 32 males.

The following code designations have been assigned to the dermatitis samples:

ND = 31 Overtly neurotic skin patients
SID = 57 Self-inflicted skin patients
UD = 73 Unanxious skin patients

The scores for each of these subgroups will be presented in the dermatitis section of this chapter.

The Normal Control Sample

A group of 38 subjects, 21 male and 17 female, made up the medical control sample. These subjects were patients seen in the dermatologist's office for skin lesions for which a definite physiological (nonpsychosomatic) cause existed—industrial dermatitis, infections, skin carcinomas, etc. These patients were tested in the same manner as the dermatitis sample and were used as a direct control. This group stands as the only sample for which there is no apparent psychiatric or psychosomatic involvement and is, therefore, designated medical or "normal" control.

The Neurotic Sample

A group of 67 patients, 23 male and 44 female, who had entered and remained in psychotherapy at an outpatient psychiatric clinic comprise the Neurotic Sample. Of all the patients seen for intake valuation at the Kaiser Foundation Clinic, less than 40 per cent go into treatment. These tend to be patients who recognize and ac-

cept the need for treatment. They tend to manifest openly the symptoms of anxiety, fear, depression, isolation, etc. They present as neurotics and do not deny emotional symptoms as do the psychosomatic samples. For this reason, they have been labeled the neurotic or therapy sample.

Motivational factors may have influenced their test results. It is likely that many of these patients were strongly desirous of therapy. They may have slanted their test responses in the direction of admitting a greater number of neurotic symptoms. The findings should be studied with these factors in mind.

The Psychotic Sample

The Psychotic Sample is composed of patients who were committed to a psychiatric hospital for inpatient custody and treatment. Six of these subjects (male) were studied while in group therapy at a state hospital. This group was combined with a sample of 22 patients, 4 male and 18 female, who were evaluated in an outpatient clinic—diagnosed as psychotic and hospitalized. A third sample of 20 patients from a private hospital was also included. The total psychotic sample is, therefore, comprised of 48 patients, 20 male and 28 female.

This sample is a heterogeneous mixture of cases. No claim is made that they are representative of psychotics in general. The sample is composed of at least two different types of psychotic patients. More than half are paranoid, i.e., underlying sadism or distrust covered by a façade of pious hypernormality. The other group includes suicidal or depressed patients who have a double- or triple-level structure of despair, resentment, and/or withdrawal. The statistics of the Psychotic Sample combine the results from both these dissimilar groups. This unquestionably blurs the results.

The Psychiatric Clinic Admission Sample

A group of 207 patients, 73 male and 134 female, comprise the Clinic Admission Sample.[6] This represents all the patients who applied for diagnostic evaluation and were tested in the Kaiser Foundation Psychiatric Clinic over a six months' period. This sample is quite heterogeneous. It includes some severely disturbed patients, some self-referred persons seeking psychotherapy; but the largest majority of patients in the clinic admission sample were referred by physicians and came under the pressure of somatic or psychosomatic symptoms or suffering from anxiety which was not internalized or attributed to

[6] This *N* does not apply to Level III. At the "preconscious" level a sample of 100 routine clinic patients was studied.

their emotional functioning. These patients are not motivated for therapy and this is reflected in their test responses.

The norms for the interpersonal diagnostic system are based on larger samples of clinic admissions. Thus, it is to be expected that the admission samples to be studied in this chapter will fall close to the center of the diagnostic circle (i.e., the mean). These selective and normative factors are important in considering the results to follow.

Behavior of the Ten Samples and the Three Dermatitis Subsamples at Level I-M

The average scores for each symptomatic group on the horizontal and vertical indices were obtained and plotted on a master diagnostic grid. Figure 33 presents the mean diagnostic placement for each of the eight samples at Level I-M.

This diagram indicates that five of the groups fall in the extreme perimeter of the upper right-hand quadrant, thus expressing in their symptomatic behavior strength and conventional normality. These include the ulcer (U), hypertensive (H), obesity (O), the unanxious dermatitis (UD), and normal control (C) samples. The self-inflicted dermatitis sample (SID) falls in the same quadrant but expresses slightly more passivity and weakness.

The clinic admission sample (A) and the psychotic sample (P) fall close to the center of the circle. This is because both of these groups are composed of two types of people—those who are denying symptoms and stressing normality and those who are admitting weakness. The overtly neurotic dermatitis sample (ND) locates in the same area.

The neurotic group (N) manifests an extreme amount of guilt and passivity.

Table 35 presents the statistical tests which indicate the significance of these differences among the symptomatic groups.

The results presented in Table 35 have considerable interest. They indicate that the neurotic group who openly accept and express anxiety are significantly different (statistically) from every other group at Level I-M.

No distinction can be made at this level between the ulcer, hypertensive, obese, unanxious dermatitis, self-inflicted dermatitis, and normal control samples. This means that these six groups tend to present the same symptomless, unanxious façade and cannot be differentially diagnosed at this level.

The overtly neurotic dermatitis sample (ND) is significantly more depressed and alienated than the six hypernormal samples. The neurotic dermatitis group is stronger and more conventional on the aver-

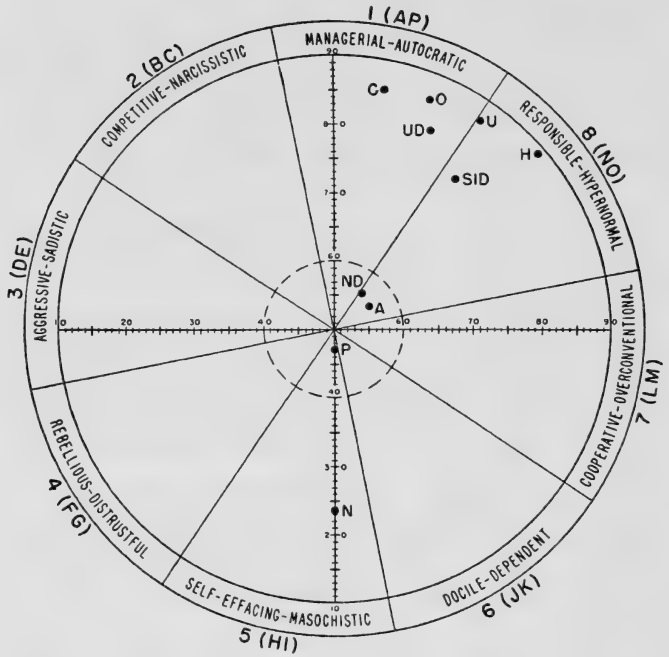


FIGURE 33. Behavior of Ten Samples at Level I-M.

Code: U = Ulcer	P = Psychotic
H = Hypertensive	N = Neurotic
O = Obese	ND = Overtly Neurotic Dermatitis
C = Dermatitis Control	SID = Self-Inflicted Dermatitis
A = Psychiatric Clinic Admission	UD = Unanxious Dermatitis

Key: The summary placement of each symptomatic group is determined by the intersection of the vertical and horizontal indices. The indices for each sample were calculated by (1) determining the number of cases in the sample falling in each of the eight diagnostic types (at Level I-M) and (2) feeding these numbers into the formulas [Vertical Index = $1 - 5 + .7(2 + 8 - 4 - 6)$ and Horizontal Index = $7 - 3 + .7(6 + 8 - 4 - 2)$, where 1 = the number of subjects falling in the *AP*-autocratic sector of the circle at this level of personality, etc.] The resulting indices express the central trend of each sample in comparison with the other seven samples. These group indices are not used in statistical tests.

TABLE 35

THE SIGNIFICANCE OF DIFFERENCES AMONG TEN SYMPTOMATIC GROUPS AT LEVEL I-M

Number of Cases	*Symptom Group*	U	H	O	C	A	P	N	ND	SID	UD
39	U	–									
41	H	NS	–								
100	O	NS	NS	–							
40	C	NS	NS	NS	–						
207	A	.001	.001	.001	.001	–					
28	P	.001	.001	.001	.001	NS	–				
67	N	.001	.001	.001	.001	.001	.20	–			
31	ND	.01	.01	.001	.01	NS	NS	.02	–		
57	SID	NS	NS	NS	NS	.001	.001	.001	.01	–	
73	UD	NS	NS	NS	NS	.001	.001	.001	.001	NS	–

Key: These significance tests are based on chi-squares—the separation being between the number of patients falling (at this level) in the strong conventional sectors (2,178) and the number of patients falling in the weak-hostile half of the circle (3,456). This is a crude over-all measure which fails to pick up specific octant differences. More detailed splits (i.e., between pairs of octants) would increase the significance indices.

age than the neurotic group. It does not differ from the psychotic and clinic admission samples.

These similarities and differences allow us to combine the groups (at Level I-M) into four categories:

Very strong and hypernormal	Ulcer, hypersensitive, obesity, normal control, unanxious dermatitis
Fairly strong	Self-inflicted dermatitis
Fairly weak, somewhat depressed and dependent	Psychiatric admissions, psychotics, neurotic dermatitis
Very weak and dependent	Patients in psychotherapy

Behavior of the Ten Samples at Level II-C

The mean Level II-C indices of the ten symptomatic groups were plotted on the diagnostic grid. These results are diagramed in Figure 34.

We observe that these results are somewhat different from the Level I scores. The neurotic sample (N) again falls in the passive, weak sector of the diagnostic circle. The clinic admission sample (A) and the overtly neurotic dermatitis sample (ND) again fall near the center. The self-inflicted dermatitis sample again falls in the upper right-hand quadrant indicating a moderate claiming of strong, responsible behavior.

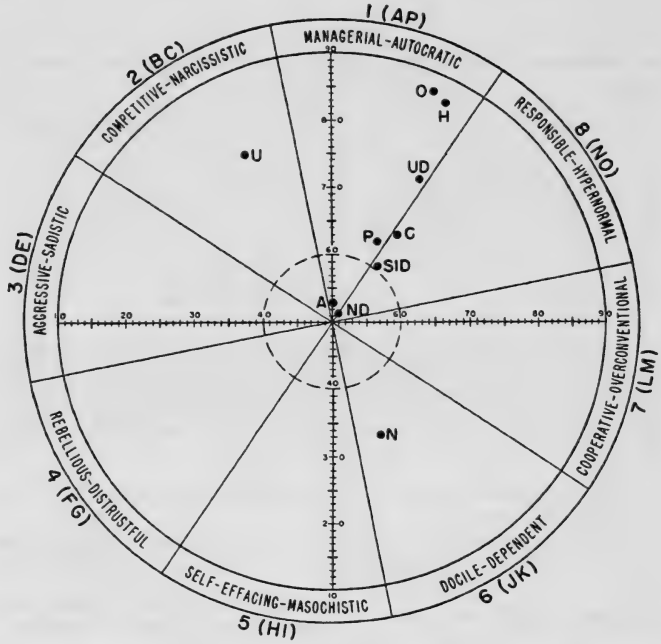


FIGURE 34. Behavior of Ten Samples at Level II-C. *Code and Key:* Same as for Figure 33.

The normal control group (C) shifts. At Level I they manifest the strongest and most symptomless façade. In their conscious self-descriptions, they do not emphasize strength, they admit to some hostile and weak behavior and almost duplicate the SID sample.

The ulcer group (U) also shifts. In their symptomatic presentation (Level I-M), they stress strength and conventionality. They consciously claim to be tougher and more aggressive. They are (at Level II-C) the most independent and hardboiled of any symptom group.

The hypertensives (H) stay (at Level II-C) in the responsible, hypernormal octant, although there is a greater emphasis on their strength.

The obesity group (O) remains power-oriented and produces a double-level façade of executive strength. The unanxious dermatitis

(UD) is the third most hypernormal managerial group at the level of self-diagnosis.

The psychotic group (P) shows a decided shift. At Level I-M they are scattered between passivity and hypernormality. At the level of conscious self-description they become overwhelmingly hypernormal. This severely disturbed group thus diagnoses itself as responsible and executive!

Table 36 presents the statistical tests which indicate the significance of these differences. These results are worth comment. The ulcer

TABLE 36

THE SIGNIFICANCE OF DIFFERENCES AMONG TEN SYMPTOMATIC GROUPS AT THE LEVEL OF CONSCIOUS SELF-DESCRIPTION (LEVEL II-C)

Number of Cases	*Symptom Group*	U	H	O	C	A	P	N	ND	SID	UD
42	U	–									
49	H	.01	–								
100	O	.001	NS	–							
41	C	NS	.01	.001	–						
207	A	.20	.001	.001	.20	–					
26	P	NS	.01	.001	NS	NS	–				
67	N	.02	.001	.001	.02	.10	.20	–			
31	ND	NS	.001	.001	NS	NS	NS	.10	–		
56	SID	NS	.001	.001	NS	NS	NS	.05	NS	–	
70	UD	NS	.05	.01	NS	.001	.10	.001	.10	.05	–

Key: These significance tests are based on chi-squares—the separation being between the number of patients falling (at this level) in the strong conventional sectors (2,178) and the number of patients falling in the weak-hostile half of the circle (3,456). This is a crude over-all measure which fails to pick up specific octant differences. More detailed splits (i.e., between pairs of octants) would increase the significance indices.

sample is extremely different from the obese and hypertensive samples. The latter claim more conventional hypernormal traits. The ulcer sample is also different from the neurotics who admit to considerably more passivity.

The obesity and hypertensive groups are very similar to each other and are significantly different from every other sample. No other group approaches their strength.

The neurotic sample is unique—no other group approaches the weakness they manifest.

The panic-psychotic sample is significantly more "normal" in its self-diagnosis than the neurotics—and shows no difference from the normal dermatitis and ulcer samples.

The similarities and differences allow us to combine the groups at Level II-C into the following general categories:

Very strong and hypernormal	Hypertensive, obesity, unanxious dermatitis
Moderately strong and hypernormal	Normals, psychotics, self-inflicted dermatitis
Very strong and aggressive	Ulcer
Very weak	Neurotic
No commitment to any modal security operation	Clinic admission, overtly neurotic dermatitis

Behavior of the Ten Samples at Level III-T

The average scores (at Level III-T Hero) for each sample were plotted on the diagnostic grid. Figure 35 indicates that dramatic

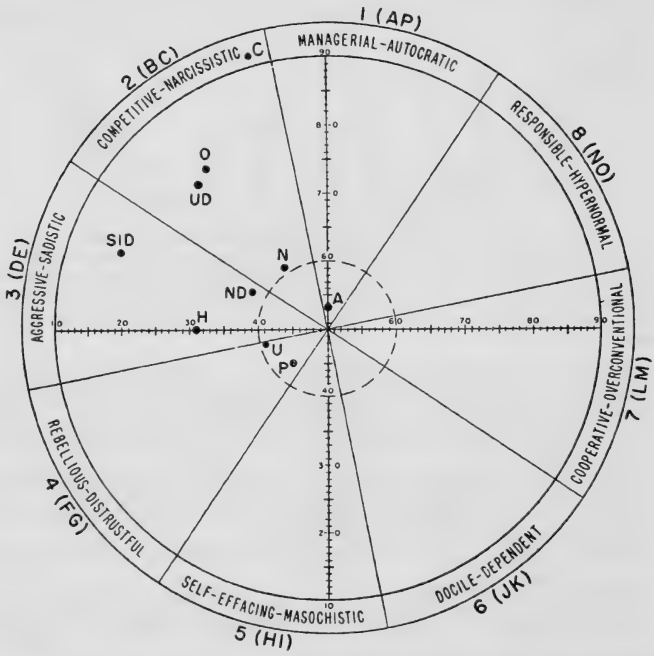


FIGURE 35. Behavior of Ten Samples at Level III-T (Hero). *Code and Key:* Same as for Figure 33.

shifts in behavior occur when this underlying level is brought into play.

The sample, which at the underlying level manifests the most strength, is the normal control (C). They fall in the competitive, narcissistic sector of the circle. The obesity sample (O) also locates in this sector, but they are not as power-oriented as the controls. At the level of conscious self-description, it will be recalled that the obese sample claimed to be much stronger than the controls. While they do not maintain this dominance in relation to the controls, they remain in "preconscious" behavior the second most confident and independent of all the samples.

The unanxious dermatitis sample (UD) expresses underlying themes of strength and hostility. This group is significantly weaker than the controls and significantly more hostile than psychiatric clinic (A) sample. The self-inflicted dermatitis sample expresses more underlying sadism than any other group.

The hypertensive (H) sample is the next most hostile. This symptom group is more committed to underlying sadistic feelings than the neurotic and clinic samples.

The ulcer (U) sample clearly differs significantly from all other psychosomatic groups (at Level III-T). This group expresses more passivity and more positive trustful themes than any other psychosomatic group. The ulcer sample is considerably more passive than the neurotic group, for example. The psychotic group (P) presents more underlying submissiveness and weakness than any other sample.

TABLE 37

THE SIGNIFICANCE OF DIFFERENCES AMONG TEN SYMPTOMATIC GROUPS AT THE LEVEL OF "PRECONSCIOUS" EXPRESSION (LEVEL III-T [HERO])

Number of Cases	*Symptom Group*	U	H	O	C	A	P	N	ND	SID	UD
19	U	–									
27	H	NS	–								
97	O	.05	.10	–							
41	C	.001	.001	.05	–						
103	A	NS	NS	.05	.001	–					
18	P	NS	NS	.05	.001	NS	–				
67	N	.20	NS	NS	.01	NS	.20	–			
33	ND	.20	NS	NS	.01	NS	.20	NS	–		
57	SID	NS	NS	.10	.001	NS	NS	NS	NS	–	
71	UD	.02	.05	NS	.05	.02	.05	NS	NS	.05	–

Key: These significance tests are based on chi-squares—the separation being between the number of patients falling (at this level) in the strong conventional sectors (2,178) and the number of patients falling in the weak-hostile half of the circle (3,456). This is a crude over-all measure which fails to pick up specific octant differences. More detailed splits (i.e., between pairs of octants) would increase the significance indices.

Table 37 presents the significance tests for the differences among these ten samples. The most interesting aspect of this table is the large number of significant differences among the psychosomatic and normal control groups. The Level III-T (Hero) score is clearly the most sensitive and powerful instrument for discriminating among these symptom groups. The normal control group, for example, is significantly different from every other sample—neurotic, psychotic, and psychosomatic.

These results lead us to conclude that several psychosomatic groups cannot be differentiated from each other or from normal, psychotic, or psychiatric samples at the two overt levels, but they can be separated with statistical significance by the use of a Level III measuring device. The importance of a multilevel approach is underlined by these findings.

The "preconscious" expressions of the ten samples can be summarized as follows:

Very strong and independent	Normal, obesity, unanxious dermatitis
Mildly independent	Neurotic
Extremely sadistic	Hypertensive, self-inflicted dermatitis
Most dependent and masochistic	Ulcer and psychotic
No trend (normative group)	Clinic admission

In the last few pages we have studied three levels of personality, discussing, in turn, the behavior of the ten samples at each level. We shall now focus, not on the levels, but on the symptomatic groups, pulling together the multilevel pattern for each sample.

Multilevel Personality Pattern of Normal Controls

When the average scores of the normal group at Level I-M, Level II-C, and Level III-T (Hero) are plotted on the same diagnostic grid, we obtain the multilevel picture for this sample. Figure 36 presents these plottings. At the symptomatic level, the normals are, as expected, strong and generate no dependent or helpless pressure. In their conscious self-descriptions, they are much less oriented towards power. Whereas they all have the same symptom-free façade at Level I, they are quite heterogeneous at Level II-C. This also seems to make sense. It indicates that normals differ in their perception of their own interpersonal roles. Some claim independence, some docile conformity, some responsibility, etc.

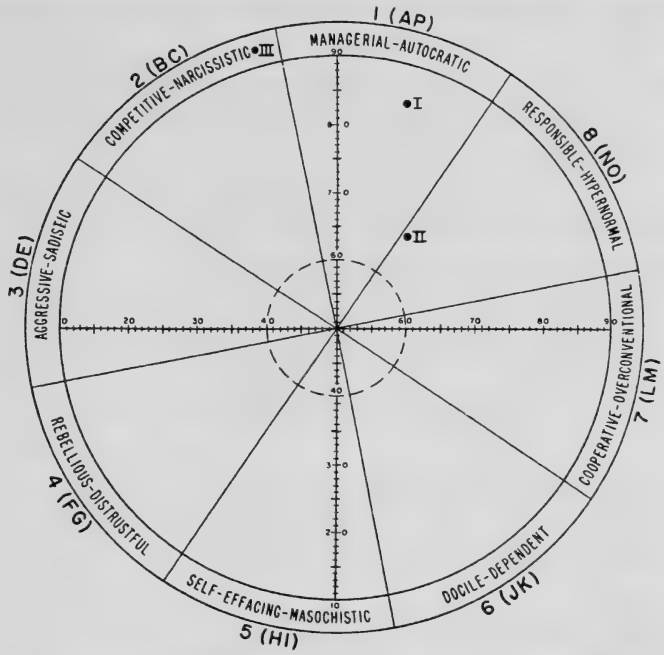


FIGURE 36. The Mean Scores of 38 Normal Controls at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

In their underlying feelings, they return to their Level I strength and independence. Their "preconscious" themes are more self-confident and narcissistic than any other sample.

The total pattern stresses executive, autonomous operations. No typical conflict exists for this group. A triple level solidity and competence is suggested.

Clinical Implications

The multilevel pattern we have just sketched represents the group tendency of a sample of normal subjects. Needless to say, the individual patients in the normal sample do not all manifest this personality pattern. No generalizations about this pattern hold for individual subjects. It may be suggestive, however, to point out the clinical im-

plication of this generic pattern—which would hold for many normal subjects.

Patients with this record would be considered as unmotivated for psychotherapy. The strong, symptom-free Level I-M, the moderately conventional self-perception, and the self-confident, independent, "preconscious" feelings all point to a lack of desire for help or personality change.

The three layers of strength suggest a durable character structure with little interlevel conflict. The prognosis points to little change. They will tend to maintain their strong security operations.

Multilevel Personality Pattern of Ulcer Patients

The average scores at three levels for the ulcer sample are plotted in Figure 37. At the symptomatic level, the ulcer group stresses re-



FIGURE 37. The Mean Scores of 41 Ulcer Patients at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

sponsibility and conventional strength. They do not admit to emotional symptoms. They manifest bland, hypernormal behavior, more so than do the normals.

In their conscious self-descriptions, they emphasize tough, independent self-confidence; they claim to be more aggressive than any other group.

In their "preconscious" imagery, a marked conflict appears. They express passivity and dependence.

The total personality pattern reveals a tremendous interlevel variability. This conflict between overt responsible independence and covert passivity is in general agreement with the findings of other research workers who have studied the ulcer personality. Internists, analytic, and nonpsychoanalytic writers alike (1, 2, 3, 4) have stressed the energetic, success-oriented traits overtly claimed by ulcer patients. Psychoanalytic authorities have further indicated that passivity and dependence underlie this strong façade. (1, 2) Our results offer objective evidence in support of these earlier clinical studies.

Clinical Implications

Patients with this profile would present a tricky diagnostic problem, and motivation for therapy is mixed. They present a responsible, aggressive, independent façade. This generally indicates a low motivation for treatment. These security operations accompany a denial of the need for help.

The underlying hostile passivity tends to work in the opposite direction. Strong "preconscious" dependence is suggested. This is often manifested indirectly. These patients are often too proud to ask for help, but their underlying feelings of helplessness may appear obliquely. A nurturant, poised behavior on the part of the therapist may link up with the patient's covert passivity.

The prognosis for patients with this extreme conflict is also mixed. These patients will inevitably become "sicker" during therapy. The sturdy, symptom-free façade wilts, and depressive, fearful, dependent feelings develop.

The prognostic issue is this: Can a patient with this severe conflict tolerate the emergence of the underlying feelings of helplessness? Two layers of overt operations are committed to maintaining strength. In some cases, the pressure of treatment (which inevitably involves tapping the "preconscious dependence") may cause unbearable anxiety. This may lead to a "flight-into-health" or depressive episodes, or long-term obsessive solutions.

The clinical course of a patient with a conflict between overt strength and underlying weakness is always complicated and un-

certain. The task of the therapist is to be sensitive to the patient's reaction to emerging passivity and to the signs of intensified anxiety.

Multilevel Personality Pattern of Hypertensive Patients

The average indices at three levels for the hypertensive sample is plotted in Figure 38. At the symptomatic level, the hypertensive group falls in the responsible-generous sector of the circle—close to the ulcer sample. In conscious self-description, they emphasize power

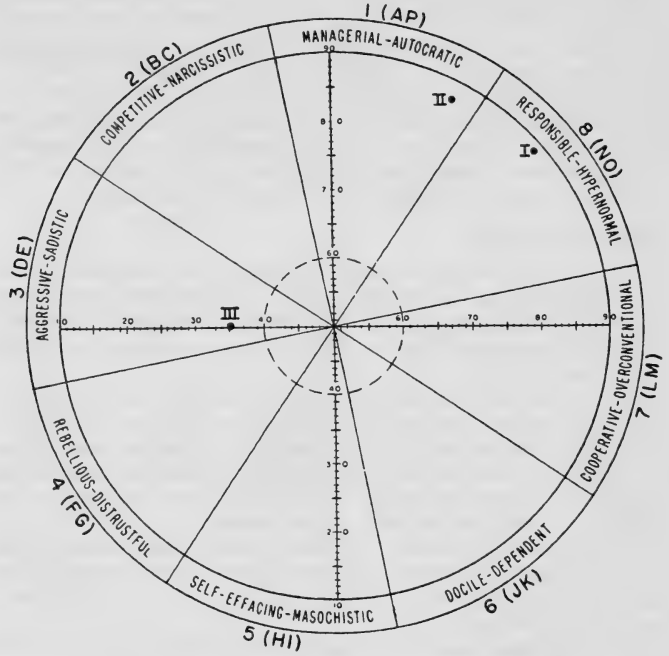


FIGURE 38. The Mean Scores of 49 Hypertensive Patients at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

and independence. On the "preconscious" measures they manifest more sadism than any other symptomatic group.

A severe conflict is indicated. The façade of conventional responsible strength covers intense feelings of rage.

These findings tend to support the clinical folklore about hypertensive patients, which describes them as denying hostility. The psychosomatic literature is less specific in its discussions of hypertensive patients. Saul points out that "on the surface these individuals were non-hostile and even overly gentle, but did not lack energy. They worked—in fact overworked—and succeeded, while protesting against doing so" (5, p. 159). Our objective data support this statement.

Clinical Implications

It is not possible, on the basis of these data, to generalize about all hypertensive patients. We can, however, suggest the clinical implications for an individual who manifests this particular multilevel pattern.

This profile does not indicate motivation for therapy. The self-satisfied, responsible façade does not lead the person to seek or accept the role of a patient. In their overt operations they are, thus, similar to the ulcer sample.

The underlying material is also mobilized against psychotherapy. The underlying hostility could be expected to be a barrier between the patient and the therapist. The ulcer patient's covert passivity functions to pull the patient (against his conscious desire) into a dependent relationship. The hypertensive patient is pushed (against his conscious desire) in the direction of angry irritation.

Patients with this pattern have a poor prognosis for psychotherapy. They overtly say that they do not need help and they covertly offer a thorny, violent picture.

These patients are made very anxious by the prospect of treatment. They generally try to "repress" out of therapy and to deny any unconventional feelings. If they do get involved in treatment, they often become paralyzed with anxiety and/or suffused with righteous anger against the therapist.

In the Kaiser Foundation Clinic, we have found hypertensives to be among the most difficult candidates for psychotherapy. They are considered to have a poor prognosis for therapy.

Multilevel Pattern of Obesity Sample

The generalizations made in this section about the obesity group are even more tentative than those made about the other samples—first, because of different selection procedures and secondly, because only female subjects are involved.

The average scores at three levels for the obesity sample are plotted in Figure 39.

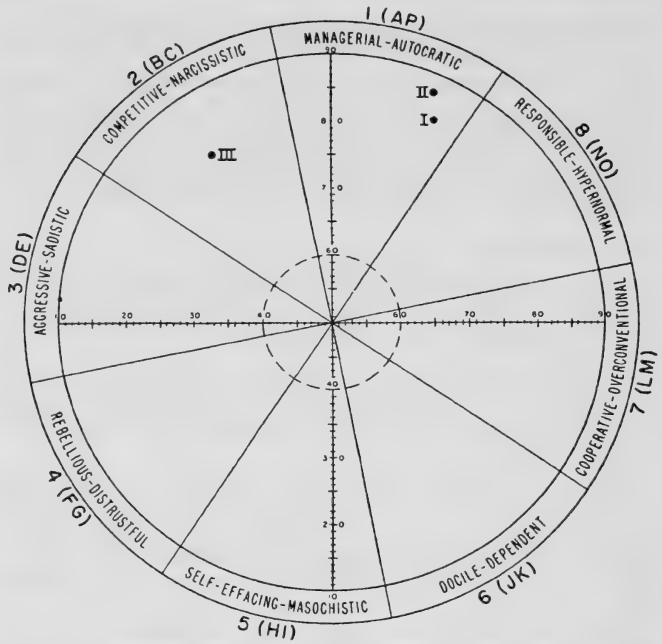


FIGURE 39. The Mean Scores of 98 Obese Females at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

Power and narcissistic pride are emphasized at all levels. This sample is, along with the normals, the least conflicted. A rigid clinging to the same security operations at each level is indicated.

Clinical Implications

These findings suggest that obese women are extremely power-oriented. They tend to duplicate the pattern of the normal controls except that they are significantly stronger than the normals at Level II. They claim inordinate strength.

There are several theoretical implications. The need to be "big," to occupy space, to swing one's weight may be motivated by and correlated with this personality pattern. The refusal of many obese patients to accept and obey dietary regimes may be tied to the stubborn, narcissistic security operations which our instruments measure.

To the extent that this triple-level pattern holds for other obese groups, it seems clear that any therapeutic approach (medical or psychological) is doomed to failure if it does not take into account these power strivings.

These patients are not motivated for psychotherapy. They are free from the classic emotional symptoms. They are not at all self-critical or dependent. Their independence and autonomy would be threatened by the prospect of treatment. Giving up their weight or their narcissistic strength would obviously run counter to their triple-level security operations and would be attended with considerable anxiety.

Patients with this personality pattern rarely enter treatment. If they do, an intense power struggle with the therapist usually results.

A three layer commitment to the same security operation indicates a rigid personality—with little change expected.

Multilevel Pattern of the Overtly Neurotic Dermatitis Sample

The mean indices at three levels of the overtly neurotic dermatitis sample are profiled in Figure 40. At the symptomatic level, this sample locates in the same sector of the diagnostic grid as the psychiatric clinic admission group. They are not as strong as the psychosomatic groups and not as weak as the neurotic sample.

At the level of conscious self-description, the neurotic dermatitis group again falls close to the psychiatric clinic sample. They are midway between the psychosomatics and neurotic samples.

In their "preconscious" expressions, the neurotic dermatitis sample is mildly aggressive.

This sample manifests a multilevel personality pattern which is very close at all three levels to the psychiatric clinic admission sample. They are also much closer to the psychotic and neurotic samples (at the façade levels, I and II) than the other psychosomatic groups. These findings make it seem reasonable to label the acne, psoriasis, and seborrheic dermatitis samples as the overtly neurotic dermatitis subcluster.

Clinical Implications

The neurotic dermatitis group manifests more depression, guilt, and alienation than any other psychosomatic sample. It might be assumed that they recognize their problems and anxieties whereas the other psychosomatic groups clearly deny these emotions. For this reason it seems that acne, psoriasis, and seborrheic patients would be more likely to accept psychotherapy. They would tend to be more

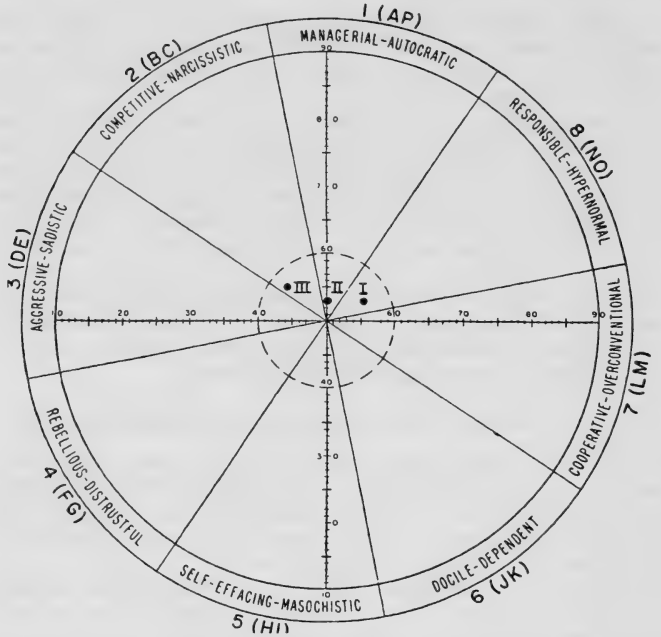


FIGURE 40. The Mean Scores of 31 Overtly Neurotic Dermatitis Patients at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

motivated for self-exploration. They are clearly less self-satisfied and bland in their overt operations.

This is not to say that all acne patients, for example, are depressed and eager for treatment. A higher percentage is likely to be found in this group than in the other psychosomatic samples.

Multilevel Pattern of the Self-Inflicted Dermatitis Sample

The average scores of the self-inflicted dermatitis sample are presented in Figure 41. These patients are hypernormal at the façade levels (I and II). Although they do not manifest as much conventional strength as the controls or the other psychosomatics they are not significantly different from these hypernormal samples.

At Level III-T these patients present more sadism than any other sample. The multilevel pattern is that of a sweet, responsible façade

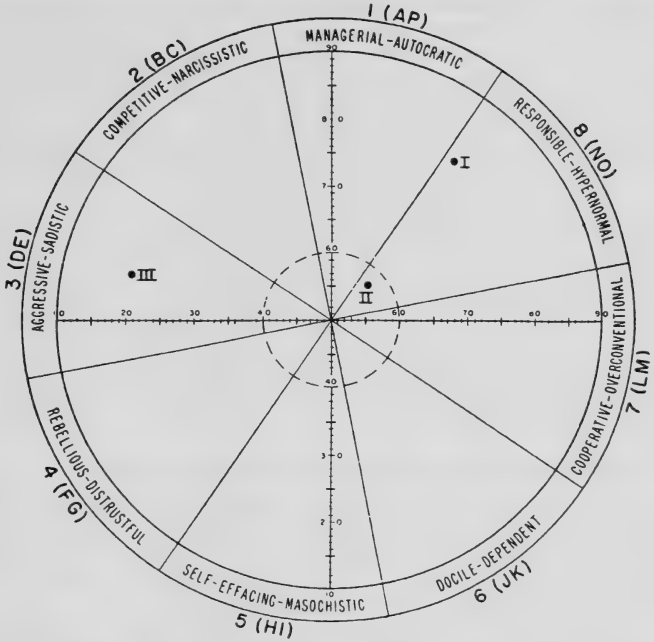


FIGURE 41. The Mean Scores of 57 Self-Inflicted Dermatitis Patients at Levels I-M, II-C, and III-T (Hero).

with underlying rage and bitterness. In light of the self-destructive nature of their self-inflicted (or self-exacerbated) symptoms the finding of intense underlying hostility is of some interest.

Clinical Implications

There are definite clinical correlates of the modal personality type exhibited by the group of dermatitis patients which comprise the excoriation sample. In the first place the façade of righteous responsibility suggests that they would not be well motivated for psychotherapy. They tend to present themselves as conventional people and to manifest the emotional symptoms of the hysterical or hypernormal personality types. They might be quite threatened by the attempt to steer them towards a psychiatric clinic. The typical case would exhibit an intense conflict between this bland exterior and underlying

sadistic rage. The hostility is apparently expressed indirectly through self-mutilation. Self-exploration would tend to disturb their equilibrium and might produce a severe anxiety reaction. This might be resolved by an increase in the façade operations (i.e., further intensification of the hypernormal response) or by a break through of the internal anger which, at the minimum, would rupture the doctor-patient relationship and, at the worst, result in psychotic aggression.

The following clinical implication suggests itself: patients with the dermatological symptoms of atopic dermatitis, otitis externa, pruritis, neurotic excoriations should not be rushed into a psychiatric referral. Any exploration of emotional factors should proceed with cautious tentativeness and avoid crashing headlong into a strongly defended, bland, self-satisfied façade. These patients may appear to be nervous. They may admit to "tension" or to being "high-strung," but they still tend to cling to a repressive, hypernormal self-image and to resist psychotherapeutic procedures. In some cases it might be expected that psychotic episodes would follow a breakdown in the precarious defenses.

Multilevel Pattern of the Unanxious Dermatitis Sample

The modal scores of the unanxious dermatitis sample are profiled in Figure 42. This group is, at all levels, stronger and more self-confident than the other dermatitis groups. They tend to be much more like the normal controls. They express much less anxiety and self-effacement than the other dermatitis groups.

The fact that this group falls so close to the controls tends to throw doubt on the presence of emotional factors. These data suggest that hyperhydrotic eczema, alopecia areata, urticaria, acne rosacea, lupus erythematous, herpes simplex, and warts are not psychosomatic disorders and that organic, physiological factors may play a more decisive role in the development of these symptoms.

The unanxious subgroup is significantly different from the neurotic dermatitis and the self-inflicted dermatitis samples. The evidence presented in this chapter suggests the hypothesis that the symptomatic groups which comprise the neurotic and self-inflicted dermatitis samples are definitely psychosomatic while the unanxious sample is not.

Clinical Implications

The multilevel picture in the case of the unanxious dermatitis sample involves three layers of strength and narcissistic self-confidence. The clinical implications are obvious. These patients are not emotionally upset. They are not motivated for psychotherapy. They

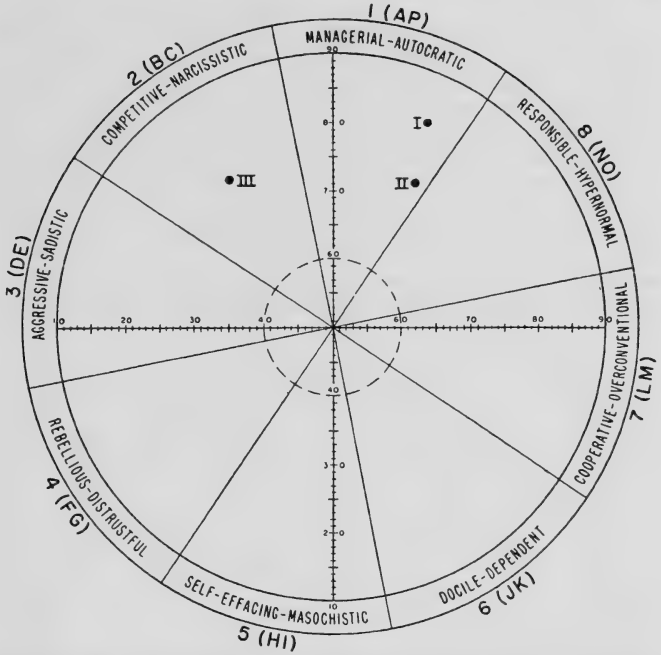


FIGURE 42. The Mean Scores of 73 Unanxious Dermatitis Patients at Levels I-M, II-C, and III-T (Hero).

will tend to maintain self-confident, independent operations and to resist psychotherapy or a psychiatric referral.

There does not seem to be as much danger of provoking anxiety in these patients. The self-inflicted dermatitis cases might be threatened by the prospect of self-exploration. The average unanxious dermatitis patient would not be disturbed by a referral to psychotherapy—he probably would actively and independently refuse it.

Multilevel Pattern of the Psychiatric Clinic Admission Sample

The average scores of the clinic admission sample at three levels are diagramed in Figure 43. This sample is composed of all patients tested during a six-month period at Kaiser Foundation Psychiatric Clinic. A very heterogeneous group of patients is included in this

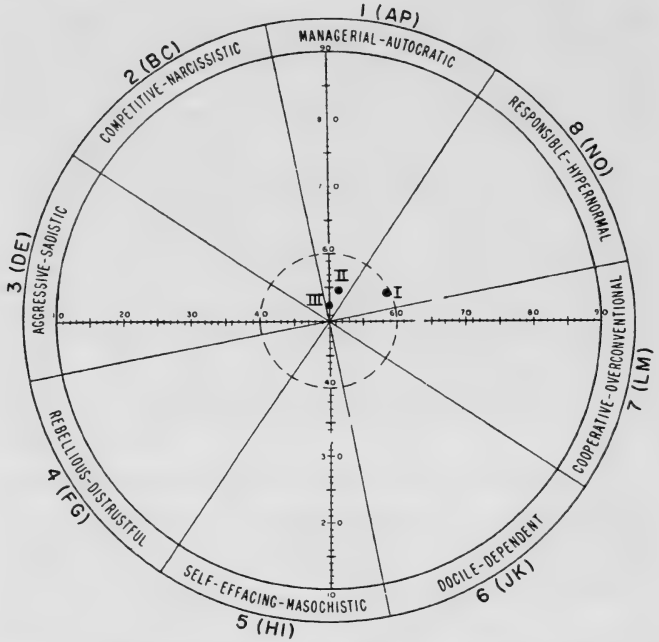


FIGURE 43. The Mean Scores of 207 Psychiatric Clinic Admission Patients at Levels I-M and II-C, and 100 Clinic Admission Patients at Level III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

sample (i.e., severe neurotics, psychosomatics, patients wanting therapy, and patients strongly mobilized against treatment). For this reason we should not expect a definite trend towards any particular interpersonal operations.

The norms used for diagnosis are based on approximately 800 clinic admissions. The present group of 207 was included in the normative sample.

This is a second and more convincing reason to expect that the means of the admission sample will fall close to the center of the diagnostic grid.

The plottings presented in Figure 43 therefore, have little diagnostic meaning but they do serve as a reference point to which the other samples can be related.

Multilevel Pattern of the Neurotic Sample

Figure 44 presents the three-level mean scores for the neurotic (psychotherapy) sample. This group comprises patients who were seen in group or individual psychotherapy. This group is, by definition, heterogeneous, since patients with several psychiatric diagnoses are assigned to therapy. The majority of these patients fall in the schizoid, obsessive, phobic, and hysteric categories. The mean scores at each level are, therefore, the resultant of different interpersonal pressures. The generalizations to follow are limited by this qualification.

At Level I the therapy sample averages out to be submissive, passive, dependent. Some of the neurotics were bitter and some conven-

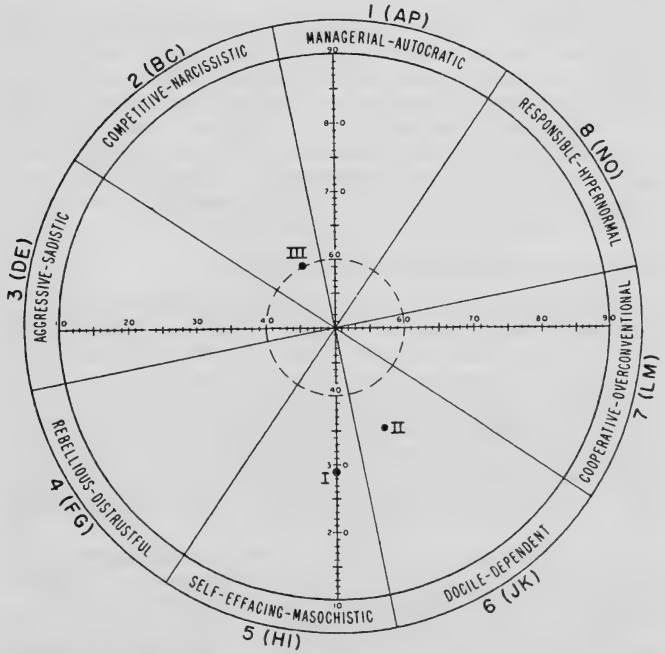


FIGURE 44. The Mean Scores of 67 "Neurotic" Patients at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

tionally agreeable so that the horizontal (love-hate) factor balances out. The large majority of the neurotics were depressed, anxious, and fearful which results in a Level I-M score which is considerably weaker than any other sample.

At Level II-C they see themselves in the same way.

In their "preconscious" expressions, a drastic change occurs. Feelings of narcissism and independence appear. At the façade levels, the neurotics were, by far, the weakest group. They use passivity as their security operation at these levels. In their fantasies they are stronger than four other samples. The psychotherapy patients tend to use overt weakness to cover underlying feelings of narcissism and self-enhancement. They are, at the preconscious level, not as docile, dependent, and timid as they claim to be or as they overtly appear to be.

Clinical Implications

This sample is so diverse that specific generalizations are limited. We can say that the neurotic sample is initially well motivated for therapy in that they present an anxious, worried, dependent façade. They are consciously dissatisfied with themselves and eager for help.

The underlying scores tell us that a typical conflict exists and that they are not as weak as they claim to be. The "preconscious" narcissism might predict, in some cases, to power struggles and feelings of superiority which may be used against the therapist or which may point to potential self-confidence and self-acceptance.

Multilevel Pattern of the Psychotic Sample

The average indices of the hospitalized psychotic sample at Levels I, II, and III are presented in Figure 45. In their symptomatic behavior, this group falls close to the clinic admission sample. This is because of the diversity within the sample. Some psychotics manifest symptoms of passivity and depression; but more of them, however, tend to deny symptoms and present as strong, healthy persons. The mean falls close to the center. It is interesting to note that the psychotics are considerably stronger and more self-possessed (at Level I-M) than the neurotics who are willing to internalize and admit to symptoms.

In their conscious self-descriptions, the psychotic group takes a unique position. In their own perceptions they are conventionally normal! They claim pious sweetness and cooperative sociability.

The results of the underlying tests tend to shatter this two-layer façade. Intense feelings of deprivation and masochistic helplessness saturate their "preconscious" fantasies.

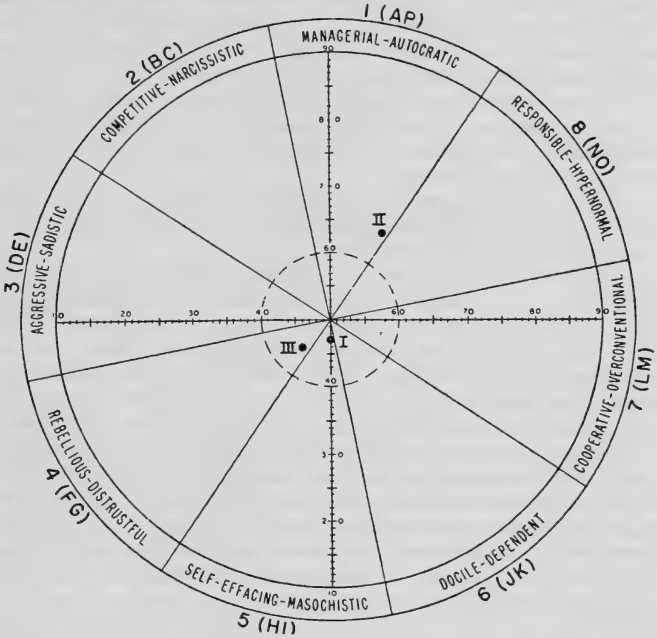


FIGURE 45. The Mean Scores of Psychotic Patients at Levels I-M, II-C, and III-T (Hero). *Key:* The summary placements for each level are based on the indices employed in Figures 33, 34, and 35.

Psychosis (according to the results from this small sample) is related in many cases to a desperate attempt to maintain a normal, conventional, innocent façade in the teeth of deeper feelings of weakness and worthlessness. In other cases psychosis is characterized by a solid multilevel structure of despair and distrust. The former are usually called paranoids, the latter catatonics or depressives.

Clinical Implications

The tentative implications to be drawn from these results are as follows: First, psychosis cannot be determined by the symptomatic pattern of the MMPI. Psychotics often present themselves as hypernormal at this level. Neither can psychotic diagnosis be determined by the patient's self-descriptions. This group is outstanding in its

tendency to claim sweet, congenial innocence. Level III (i.e., the TAT) seems to be a useful instrument, since it statistically separates the psychotics from other groups (e.g., controls and dermatitis patients) who have a similar conventional façade.

Whenever a patient presents a multilevel pattern which involves claimed conventional friendliness contrasted with a distrustful or a masochistic Level III score, the danger flag should be flown. This is the paranoid phenomenon.

This pattern indicates poor motivation for therapy. The patient claims to be a normal person and probably does not want his personality investigated or changed.

This pattern invariably involves projection of hostility and blame onto others. The symptoms and the underlying pathology are not consciously accepted or internalized. Negative feelings are attributed to external forces. At best, this forecasts a difficult prognosis. The patient disclaims responsibility for his troubles. It often predicts to a prepsychotic picture.

A second pattern typical of many hospitalized patients involves no conflict and is characterized by solid, three-level distrust and isolation. The clinical implications for this subgroup are quite different. These patients are well motivated for treatment. They will be willing to admit and display their guilt and passivity. They have a very slow prognosis for change because of the severity and deep-seated nature of the self-punitive feelings. They are often interminable cases.

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25

Analysis of Group Dynamics in an Industrial Management Group

The social behavior manifested by any individual represents his method for warding off anxiety. Interpersonal security operations make the individual more comfortable. They also tend to create the social world in which the individual exists by means of mutual training processes. Reciprocal interpersonal relationships develop in which each partner trains the other to respond in a consistent way. The sado-masochistic relationship is a common symbiotic pairing. Weakness and fear on the part of one pulls impatience and contempt from the other—which in turn increases the fear of the masochist.

These symbiotic relationships are extremely difficult to change. The involuntary, automatic nature of interpersonal reflexes makes them almost impossible to control. The reinforcing factor makes them resistant to alter because both partners are exerting pressure in the same direction. A tight symbiotic lock often develops from which neither partner can extricate himself.

These relationships occur whenever human beings are in consistent contact with each other. Marital and familial interpersonal linkage are the most common subject matters for psychological study. Most of the time and energy expended in psychotherapy is devoted to understanding and loosening familial locks.

Another most common setting for rigid interpersonal relationships is the occupational. Persons who work regularly together inevitably develop patterns of interaction which can make for a comfortable and productive job situation or which can lead to pain, anxiety, and disorganization.

One of the tasks of the psychological consultant for industry is to diagnose and help correct pathological interpersonal patterns which often exist in management groups. Before World War II, the indus-

trial psychologist typically concentrated on the noninterpersonal factors relating to productivity—time-and-motion studies, intelligence and aptitude testing, employee morale, etc. More recently, psychological consultants have discovered that personality characteristics of employees and executives and group dynamics factors play a crucial role in productivity and job satisfaction. This shift to a clinical approach to industrial problems has been accompanied by a shift in the status level of the subjects studied. It has become increasingly clear that emotional maladjustment or a rigid interpersonal operation in the case of a top-level executive can initiate a pattern of destructive events which can affect hundreds of people. In the clinic we work from the standpoint of the individual, and we assume that the maladjustment and suffering of the individual is to be treated regardless of the status and power level of the patient. The psychologist who accepts the job as consultant to an industrial firm or a labor organization often devotes most of his energies to the top-management executives. Increased insight and decreased anxiety at the top level usually bring about a greater social gain. If a union shop steward is narcissistic and dictatorial, he takes away a fraction of the union's over-all efficiency. If the regional director of the union is narcissistic and dictatorial, he may cause crippling reverses to his organization and involve hundreds of subordinates in painful experiences.

Similarly if a store-to-store salesman is sadistic and exploitive, he may cut the firm's dollar volume by a few hundred dollars. Sadistic and exploitive operations on the part of the vice-president in charge of sales may cost a corporation millions of dollars and set up a cycle of sado-masochistic behavior in scores of people who work under him.

In many cases interpersonal diagnosis can assist the psychological consultant to understand the misperceptions of self and others, the rigid patterns of interpersonal reactions which lock group members in destructive relationships. This chapter presents a case-history illustration of the use of the interpersonal system in analyzing group dynamics in a top-level executive group.

The Top-Management Group[1]

The group to be discussed comprised four executives who were responsible for the management of a manufacturing and distributing plant of a nation-wide corporation. Personality evaluations were made of the top level executives of this plant—and during the assessment process each person took the interpersonal checklist four times —rating himself and his perceptions of the other three executives with

[1] Certain changes in the descriptions of this industrial organization were made in order to preserve anonymity.

whom he worked closely. The consulting psychologist, after completing his diagnostic interviews rated each subject on the interpersonal adjective check list.

The four executives tested were:

The General Manager (coded GM)
The Production Manager (coded PM)
The Sales Manager (coded SM)
The Personnel Manager (coded LM)

Interpersonal tests provided several kinds of data useful in understanding the network of relationships existing in this management group. The Level II-C scores provide a picture of how each person sees himself. The pooled ratings of the other three executives (plus the psychologist) provide for each person a Level I-S measure of his general social stimulus value. When the ratings that each person made of each specific "other" are inspected, the patterns of misperception and the reciprocal relationships linking each pair to each other become obvious.

Interpersonal diagnosis of the network of interpersonal relationships existing in groups is facilitated by the use of a printed booklet. This form, entitled "Record Booklet for Interpersonal Analysis of Group Dynamics," was used in the diagnosis of this management group. The booklet of one member (the Sales Manager) of the group is presented as Figure 48 in this chapter. This reproduction of the booklet outlines the exact operations for measuring the dynamics of the subject's relationships with his colleagues. The booklets of the other three executives are not reproduced, but the summary diagrams of their perceptions of self and others are presented where appropriate to illustrate the text.

The Level II-C Perceptions of Self by Four Executives

Figure 46 presents the Level II-C self-perceptions of the four executives. All of them see themselves as strong, hypernormal, and responsible. All four scores fall in the upper right-hand quadrant. We note that the Production Manager (PM) attributes more strength to himself, while the Personnel Manager (LM) claims the most friendliness. All of them deny hostility and weakness.

The Level I-S Ratings by Four Executives

When the ratings of each subject by his three colleagues (plus the psychologist) were pooled and plotted, a measure of public stimulus value was obtained. Figure 47 presents these Level I-S scores for each subject. This diagram also includes arrows linking the Level I-S

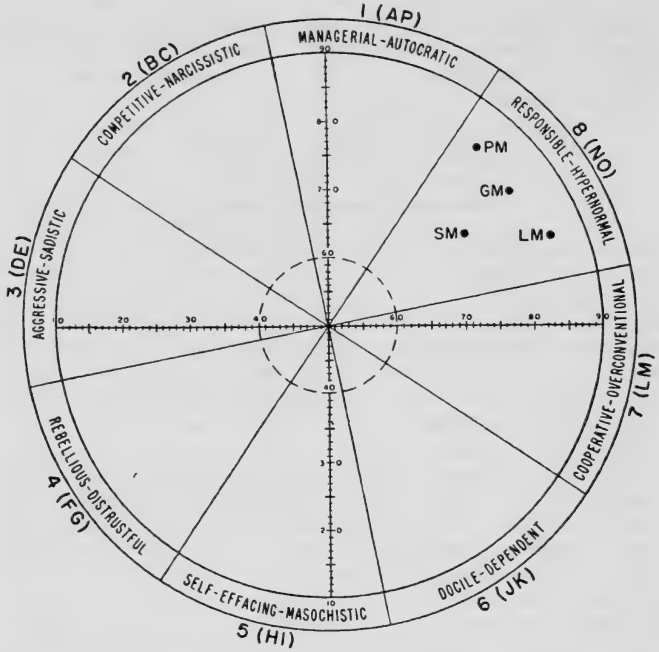


FIGURE 46. Self-Descriptions of Four Executives.

Key: GM = General Manager PM = Production Manager
SM = Sales Manager LM = Personnel Manager

scores to the Level II-C self-descriptions. The linear distance between these two scores defines the index of self-deception. The longer the arrow the larger the misperception, i.e., the greater the discrepancy between the self-descriptions and the self-as-seen-by-others. The direction of the arrow indicates what the subject misperceives.

Figure 47 tells us that the *General Manager* (GM) has the most accurate self-perceptions. He is probably the most effectively functioning member of this group. His colleagues (and the psychologist) see him as a strong forceful, nonhostile person. They clearly admire and respect him. There is a minor misperception in that he claims to be more sympathetic and friendly than he acts, and he fails to perceive some of his bossy tendencies. On the whole, he can (from the psychological standpoint) be considered a successful general manager.

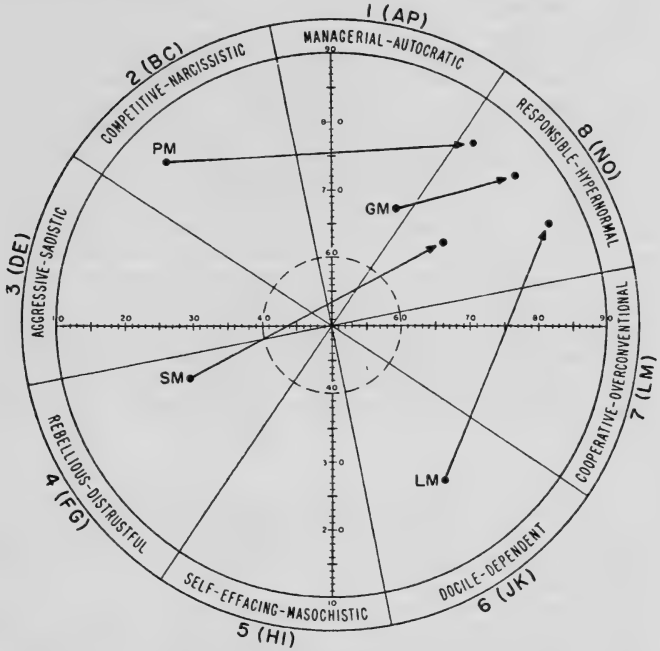


FIGURE 47. Social Stimulus Value of Four Executives, Plotted Indices of Self-Deception. *Key:* The labeled points (e.g., PM) represent the pooled Level I-S behavior of the subject as rated by others. The arrows link the Level I-S score to the subject's self-perception. The length of the arrow indicates how much self-deception exists. The direction of the arrow indicates what the subject misperceives.

The *Production Manager* (PM) manifests a much larger misperception. He is seen by others as an extremely cold, hard, unfriendly, selfish person. They fear him. They do not like him. Not one friendly or sympathetic trait was attributed to him. When we compare his Level I-S social stimulus value with his self-report a grave misperception exists. He claims to be strong and somewhat friendly. He completely denies the hostility and coldness which others see in him. This discrepancy is always diagnostic of unsuccessful interpersonal relations and poor emotional communications. The Personnel Manager believes he operates on the basis of an impersonal, respected strength. He is probably puzzled and frustrated when others react to him as a conceited and sadistic person. Harmonious and

accurate relationships cannot exist in this group until this misperception is corrected.

The *Sales Manager* (SM) is even more self-deceived. He is seen by others as a bitter, suspicious, nonconventional member of the executive group. He, on the other hand, thinks of himself as a friendly, affiliative tolerant person. It is very easy to deduce the confusion and dissatisfaction which occurs when he communicates with the others. He sees his ideas coming from a tolerant, respected person. The others see his ideas coming from a sour, rebellious, unfriendly person. This discrepancy is strong evidence for (1) a severe personality maladjustment and (2) a chaotic and confused set of interpersonal interactions.

The *Personnel Manager* (LM) is also an inaccurate judge of his own interpersonal stimulus value. He prides himself (at Level II-C) as being a friendly, likable, cooperative person. He is seen by his colleagues and the psychologist as a weak, dependent conformist. It is clear that what he sees as agreeability is actually registered by others as slavish docility. The personnel manager is clearly looked down upon by the others. They show little respect for him.

Analysis of Group Dynamics

In studying the over-all pattern of the group's interrelationships, the first point to be noted is that all members see themselves as responsible or hypernormal (octant 8). This is a consciously self-satisfied group.

So far as the public observed behavior is concerned this group is extremely centrifugal. A wide variety of intense maladaptive behavior is revealed. No member is diagnosed by others as responsible or hypernormal. Their Level I-S diagnoses are: autocratic, narcissistic, distrustful, and dependent. Two members are seen as being quite hostile. One is seen as extremely weak. A pathological network of interpersonal relations invariably accompanies extreme left-hand and bottom scores. It is possible to diagnose this as a fairly "sick" group.

It is moreover a most misperceptive group. Three of the members fail by a wide margin to perceive accurately their own interpersonal roles. The mean discrepancy score (the linear distance in centimeters between Level I-S and Level II-C) can be used as an index of the group's over-all tendency to misperceive. This mean self-description score can be compared with the mean discrepancy distance of other groups and a relative index of group misperception is obtained. This top-level management group has a self-deception score of 81.[2] This is considerably larger than the mean of psychotherapy groups com-

[2] The methods for measuring variability indices such as self-deception are described in Chapter 13.

prised, for the most part, of self-referred severe neurotics. Not enough data on management groups has accumulated to develop norms, but it is safe to say that this group of executives is considerably more self-deceived than the average.

The three estimates of group dynamics thus lead us to diagnose this group as disturbed: (1) they exhibit an extreme amount of hostility or weakness; (2) each person sees himself as hypernormal or responsible; and (3) they are markedly self-deceived. Some form of psychological counseling is clearly in order.

The Network of Relationships

In addition to the generalized analysis of the dynamics of the total group (just presented) the sociometric tests make possible a detailed analysis of the network of relationships. This is accomplished by studying in turn how each person rates each other person in the group. In discussing human relations factors with these men or in understanding their interactions it is most useful to consider the pairings which occur.

The Sales Manager

The Sales Manager was a brilliant, aggressive, colorful man—who had been extremely successful in the company before his transfer to the present location. His originality and nonconforming creativeness which had worked well in the previous office situation (where his individuality was sympathetically encouraged) had degenerated into a bitter rebellion. His job frustration led to heavy drinking, outbursts of resentment, and a suspicious distrust of his colleagues.

The perceptions by the Sales Manager of his colleagues and their perceptions of him were entered in the "Record Booklet for Interpersonal Analysis of Group Dynamics." This form provides a systematic procedure for plotting the network of relationships in which the subject is engaged. Figure 48 is a reproduction of this booklet presenting the detailed operations for interpersonal diagnosis.

The upper diagnostic circle in this figure indicates that all observers see the Sales Manager as a hostile, bitter person. All his Level I-S scores fall in the *DE* and *FG* octants. The Personnel Manager attributes more strength to him than do the rest. This is a misperception and represents the Personnel Manager's fearful, masochistic tendencies. The Production Manager sees the Sales Manager as defeated and weak—anything which is unconventional is seen as weakness by the Production Manager. Note the complete misperception of his own behavior—i.e., the difference between his own and the others' views of him.

The lower diagnostic circle in Figure 48 presents his perceptions of the other executives. He despises the Personnel Manager whom he sees as weak. He lumps the Production Manager and the General Manager together as unsympathetic, autocratic people. His failure to differentiate the two represents a pessimistic and suspicious feeling of persecution. He attributes no friendliness to any of them (they are all on the left of the vertical line). He lives in a cold, unloving environment. The lower diagnostic circle in Figure 48 also contains the consensual diagnosis of each group member. These are the lower-case letter codes (e.g., "gm"). The perceptions of the Sales Manager can now be compared with the consensual or pooled diagnosis. The difference between the two scores is an index of misperception. The Sales Manager's perceptions (capital letters) are linked by lines with the pooled summary perception of each other member by the remaining group members (lower-case letters). This illustrates the variability index of misperception—i.e., the difference between the Sales Manager's view and the consensual view by the group of each member. His view of the Production Manager is extremely accurate. His view of the other two members is quite inaccurate. He attributes more hostility to both members than the consensus.

Figure 48 reveals the following relationships.

(1) The Sales Manager erroneously sees the General Manager as being as hardboiled as the Production Manager. This is unfortunate because he cuts himself off from a potential source of support. The General Manager, we remember, prides himself (Level II-C) on his benevolence. The pressure of the Sales Manager's bitter distrust inevitably wounds the General Manager's picture of himself. He is made anxious when he is not being obeyed and respected. The Sales Manager's rebelliousness thus isolates him further.

(2) The Production Manager looks down on the Sales Manager, seeing him as an extremely resentful, complaining person. A loaded relationship exists. The Production Manager is perfectly placed (on the interpersonal grid) to bring out in exaggerated form the Sales Manager's distrust. A vicious reverberating circuit is set up between the two. The Production Manager feels justified because the Sales Manager flies off on bitter, complaining, suspicious harangues. The latter feels justified because the Personnel Manager's superior scorn inevitably infuriates him. Both men are pushing each other further in the direction of their pathological reflexes. Outside intervention by the psychologist or the General Manager is clearly necessary to break up this destructive lock.

(3) The Sales Manager's relationship with the Personnel Manager is also destructive. He is a rebellious person—made anxious by con-

Record Booklet For
Interpersonal Analysis of Group Dynamics

Subject SALES MANAGER Age 44 Sex M Date

Address City Phone

Education 14 YEARS Occupation SALES MANAGER Marital Status M

Group Leader Date Group Began

Socio # 1 given after sessions. Date Group Ended

Meeting time:
Day Hour Total Number of Sessions

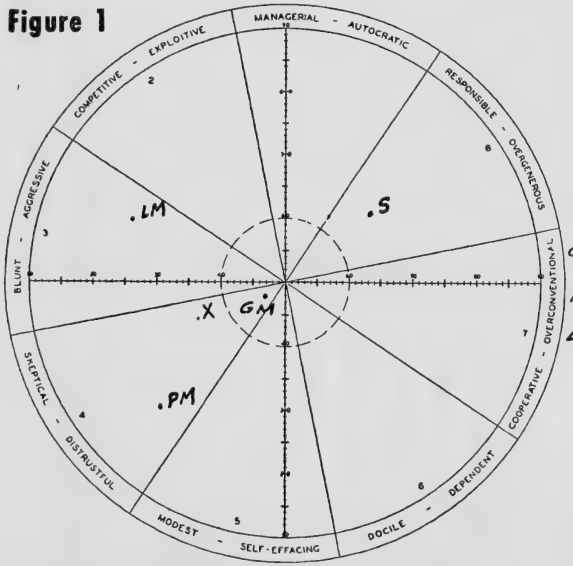
Members of Group	Initial	Remarks
Subject SALES MANAGER	SM	
Other Members (Arrange Alphabetically)		
GENERAL MANAGER	GM	
PRODUCTION MANAGER	PM	
PERSONNEL MANAGER	LM	

This booklet was prepared by Timothy Leary, Ph.D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California. Checklists, booklets, templates, norms, and instruction manuals can be obtained from the Psychological Consultation Service.

FIGURE 48.

Subject SALESMANAGER as Seen by Members of Group

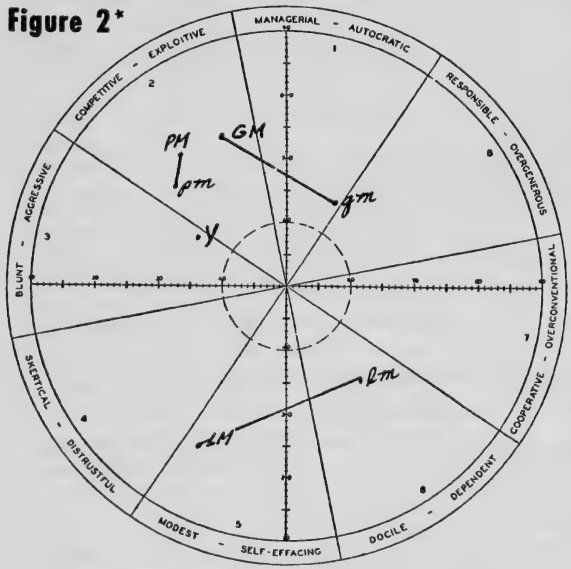
Figure 1



Key to Capital Letters in Figure 1	Interpersonal Diagnosis of Subject
X = Pooled total of group's perception of subject	4
S = Self-perception	8
GM = Subject by GENERAL MGR.	4
PM = Subject by PRODUCTION MGR.	4
LM = Subject by PERSONNEL MGR.	3
___ = Subject by ___	___
___ = Subject by ___	___
___ = Subject by ___	___
___ = Subject by ___	___

Subject _____'s Perceptions of Members of Group

Figure 2*



Key to Capital and Small Letters in Figure 2

Interpersonal Diagnosis of Fellow Group Members by Subject SM (From Table I--use capital letters)		Interpersonal Diagnosis of Fellow Group Members by Total Group (From Table III--use small letters)	
Member GM =	2	Member gm =	1
Member PM =	2	Member pm =	2
Member LM =	5	Member lm =	6
Member _____ =		Member _____ =	
Member _____ =		Member _____ =	
Member _____ =		Member _____ =	
Member _____ =		Member _____ =	
Y (Total Group) =	3		
S (Self perception--same as above) =	8		

* The small letters represent the pooled total of the group's perceptions of each member, exclusive of his own self-rating. For example, "h" = the group's perception of the behavior of member "H". "H" = the subject's perception of member "H". The distance between "H" and "h" on the diagnostic grid is an index of the misperception by the subject of his fellow group member, "H".

FIGURE 48 (*cont.*)

Indices for Measuring Group Dynamics (Misperceptions of Self and Others)

Verbal Definition of Index	Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Standard Score Discrepancy	Verbal Definition of Index	Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Standard Score Discrepancy
Conscious Identification *Use capital letter initials from key to Figure 2*							Conscious Identification with	S LM	85	-88	-58	105	
Self Deception	SX	84	-64	-94	114		Conscious Identification with	S__					
Conscious Identification with Total Group	SY	83	-21	-103	105		Conscious Identification with	S__					
Conscious Identification with	S GM	82	+15	-79	81		Conscious Identification with	S__					
Conscious Identification with	S PM	82	+15	-79	81		Conscious Identification with	S__					
Subject's Misperception *This misperception index is the distance between capital and small letter initials for any fellow group member in Figure 2.*							Subject's Misperception of	— —					
Subject's Misperception of GM	GM gm	21	+9	+43	44		Subject's Misperception of	— —					
Subject's Misperception of PM	PM pm	22	0	0	0		Subject's Misperception of	— —					

Subject's Misperception of LM	LM Pm	56	+9	+43	44		Subject's Misperception of	— —					
Misperception of Subject by Others *This misperception index is the distance between X and the capital letter summary of the appropriate fellow group member from Figure 1. Fill in the blank with the appropriate capital letter*							Misperception of Subject by	X__					
Misperception of Subject by	XLM	44	+13	+19	23		Misperception of Subject by	X__					
Misperception of Subject by	XPM	44	0	0	00		Misperception of Subject by	X__					
Misperception of Subject by	XLM	43	+43	-9	44		Misperception of Subject by	X__					

Verbal Summaries of Group Dynamics

The subject misperceives his own REBELLIOUS DISTRUST

The subject is identified with NO ONE

The subject is disidentified with ALL THREE-MOST DISIDENTIFIED WITH PERSONNEL MGR'S WEAKNESS

The subject sees GENERAL MGR as EXPLOITIVE [1]and is seen by him as REBELLIOUS-DISTRUSTFUL [2]

The subject sees PRODUCTION MGR as EXPLOITIVE and is seen by him as REBELLIOUS-DISTRUSTFUL

The subject sees PERSONNEL MGR as MASOCHISTIC and is seen by him as SADISTIC

The subject sees _____ as _____ and is seen by him as _____

The subject sees _____ as _____ and is seen by him as _____

The subject sees _____ as _____ and is seen by him as _____

The subject sees _____ as _____ and is seen by him as _____

[1]Fill in the name of the fellow group member and the verbal diagnosis for the sector in Figure 2 in which he falls.
[2]Fill in the verbal diagnosis for the sector in Figure 1 in which the group member saw the subject.

FIGURE 48 (*cont.*)

Tally Sheet: Table I

Subject_____'s Perceptions of Himself and of the Members of His Group
(Providing Capital Letter Locations for Figure 2)

Subject_____'s Perceptions of:		Octant Totals								Total Items Checked	Raw Score Formulae		Standard Scores	
Name	Initial	1	2	3	4	5	.6	7	8		D-S	L-H	D-S	L-H
1. of Self SALES MANAGER	SM										+5.5	+14.0	61	64
2. of GENERAL MANAGER	GM										+15.8	-7.4	74	40
3. of PRODUCTION MANAGER	PM										+14.7	-13.5	72	33
4. of PERSONNEL MANAGER	LM										-21.4	-11.1	26	36
5. of														
6. of														
7. of														
8. of														
Total of perceptions of the group members														
										Total divided by N – 1 = Y			57	36

Table II

The Perceptions of Subject SM
BY the Members of His Group (Providing Capital Letter Locations for Figure 1)

Subject seen by:	Raw Scores D-S	Raw Scores L-H	Standard Scores D-S	Standard Scores L-H
By GM	-4.7	-0.8	48	47
By PM	-19.0	-15.7	30	30
By LM	+4.5	-19.9	59	26
By				
By				
By				
By				
Total			X	X
Total divided by N – 1 = X			46	35

Table III

Summed Perceptions by Group of Each Member
(Providing Small Letter Locations for Figure 2)
Excluding Subject of Booklet and Member Considered

Group's Perceptions of: Name	Initial (Small Letter)	Raw Totals D-S	Raw Totals L-H	Raw Totals Divided by N-2 D-S	Raw Totals Divided by N-2 L-H	Standard Scores.. D-S	Standard Scores.. L-H
GEN. MGR.	gm	-7.5	+43.8	-2.5	+14.6	50	65
PROD. MGR	pm	+36.0	-40.2	+12.0	-13.4	69	33
PERS. MGR	lm	-39.6	+44.4	-13.2	+14.8	37	65

FIGURE 48 (*concluded*)

formity and blind obedience. The Personnel Manager, who epitomizes these docile interpersonal reflexes, stands as a continual annoyance and threat to him. He responds to the Personnel Manager with contempt and sarcasm. The Personnel Manager is obviously afraid of the Sales Manager, describing him as aggressive and sadistic.

The General Manager

The General Manager is a relatively young executive, well-trained in both the technical and managerial aspects of his job. He had made a rapid advance in the corporation and is about ten years younger than the Production and Personnel managers.

Figure 49 presents his perceptions of his colleagues. He shares the consensus view of the Production Manager, seeing him as cold and

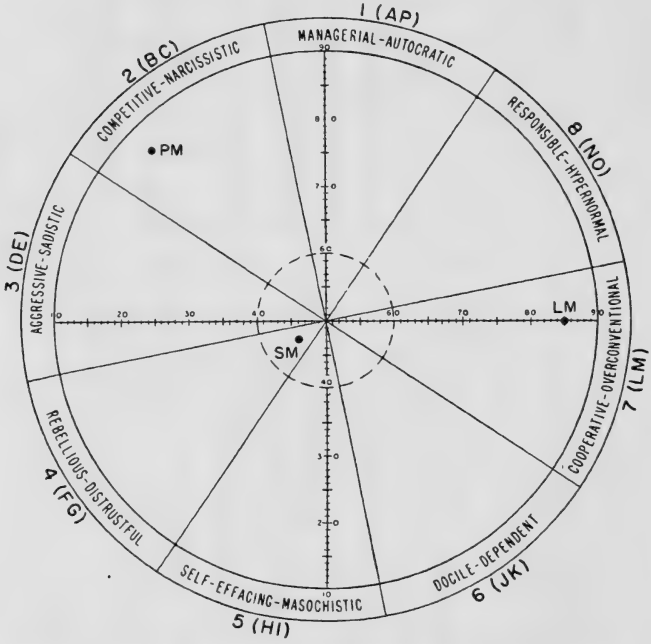


FIGURE 49. The Perceptions *by* the General Manager of His Three Colleagues.
Key: PM = The General Manager's description of the Production Manager
SM = The General Manager's description of the Sales Manager
LM = The General Manager's description of the Personnel Manager

self-centered. He respected his technical abilities but disapproved of (and somewhat feared) his cold, impersonal, conceited approach.

He has mixed feelings towards the Sales Manager. He attributes less hostility to him than do any of the other raters (see Figure 48) and bends over backwards to understand and tolerate the Sales Manager's rebelliousness.

The General Manager clearly likes the Personnel Manager. He sees him as cooperative and agreeable. This is a misperception. The rest of the raters see the Personnel Manager as a docile, weak person. The Personnel Manager placates and submits and flatters the General Manager, winning the latter's approval.

The General Manager tends to "stress the positive" in his approach to the Sales Manager and the Personnel Manager—failing to see the bitterness of the former and the weakness of the latter.

Figure 50 summarizes the perceptions of the General Manager by his colleagues and the psychologist. This diagram indicates that the Production Manager attributes the least amount of strength to the General Manager. He views him as too easygoing. We suspect that the Production Manager feels somewhat superior to his boss and thinks he is too soft. The Personnel Manager tends to idolize his boss. He attributes strength and responsibility to him. The Sales Manager assigns more hostility to the General Manager than any other rater. This indicates that he feels somewhat resentful and misunderstood by his boss. The psychologist emphasizes the executive autocratic traits of the General Manager.

The data from Figures 49 and 50 can now be combined in a series of statements summarizing the General Manager's interpersonal relationships.

(1) He is involved in an uneasy truce with the Production Manager. He respects but disapproves of the latter's coldness. The Production Manager respects but looks down on the General Manager and feels he is too soft and tolerant.

(2) He is involved in an authority problem with the Sales Manager. He strives to be sympathetic and benign in his approach to his touchy, rebellious subordinate, but this does not prevent the latter from distrustfully projecting coldness on him. These two need to be helped to clarify their mutual misperceptions. The General Manager is not as self-centered and exploitive as the Sales Manager fears.

(3) He is locked in a tight and mutually self-deceptive relationship with the Personnel Manager. They both try to believe that they have a collaborative, friendly union of equals. Actually an intense leader-follower association exists. The Personnel Manager fails to see how passive and placating he is with his boss, although all three of the other

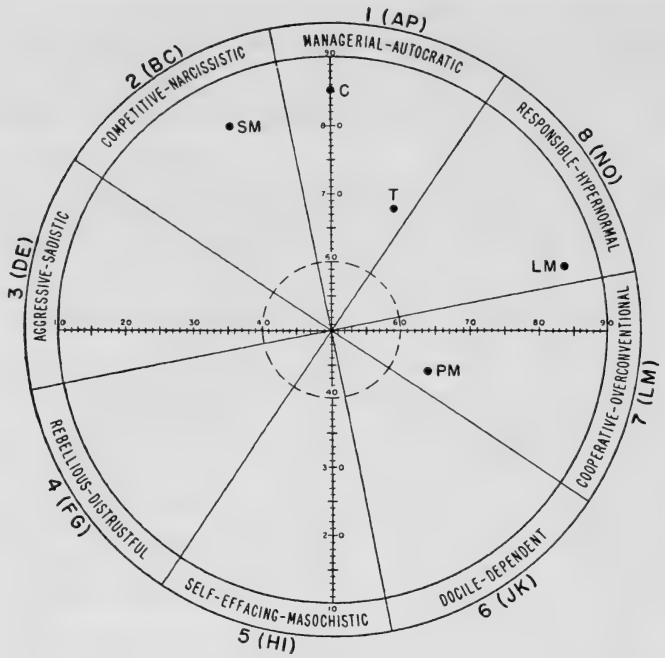


FIGURE 50. The Perceptions *of* the General Manager by His Three Colleagues and the Consulting Psychologist. *Key:* The General Manager as seen by:

PM = Production Manager
SM = Sales Manager
LM = Personnel Manager
C = Psychological Consultant
T = Pooled scores of all four

observers are aware of this (see Figure 54). The General Manager fails to perceive how autocratic and paternalistic he is towards the Personnel Manager. A symbiotic, mutually self-deceptive relationship of this sort can proceed indefinitely in harmony—except for the impact it has on others. The Production Manager was contemptuous of both of them—and the Sales Manager was jealous of the approval obtained by the Personnel Manager (whom he saw as a mollycoddle) and resentful that the General Manager did not approve of him.

The Production Manager

The Production Manager is a firm, rigid, self-confident, self-made man of the old school. He had no understanding or patience for the soft-headed management policies which were developing in his company. Human relations bored and irritated him. He expected people to behave with the efficiency of his machinery and despised any deviations from custom or rule.

Figure 51 reflects the superiority he felt over his colleagues. He rates all of them below the horizontal line—which means he sees none of them as strong. He is particularly contemptuous of the Sales Manager and Personnel Manager. He saw the former's unconventional,

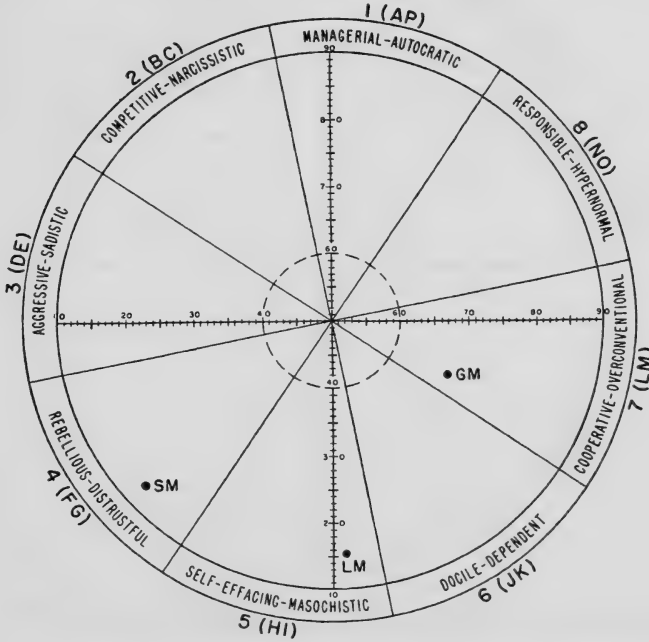


FIGURE 51. The Perceptions *by* the Production Manager of His Three Colleagues.

Key: SM = The Production Manager's description of the Sales Manager
LM = The Production Manager's description of the Personnel Manager
GM = The Production Manager's description of the General Manager

creative rebelliousness as a woolly-headed complaining. He saw the latter's docility as abject slavishness.

Figure 52 tells us that everyone agrees in labeling the Production Manager as a cold, stubborn, hardboiled person. Even the psychologist feared him—which is perhaps due to the Production Manager's outspoken disdain for psychological consultation.

Summarizing the data from Figures 51 and 52 we can see that the Production Manager is involved in the following relationships:

(1) He looks down somewhat on the General Manager, but likes him and recognizes his warmth. His rigid commitment to order and

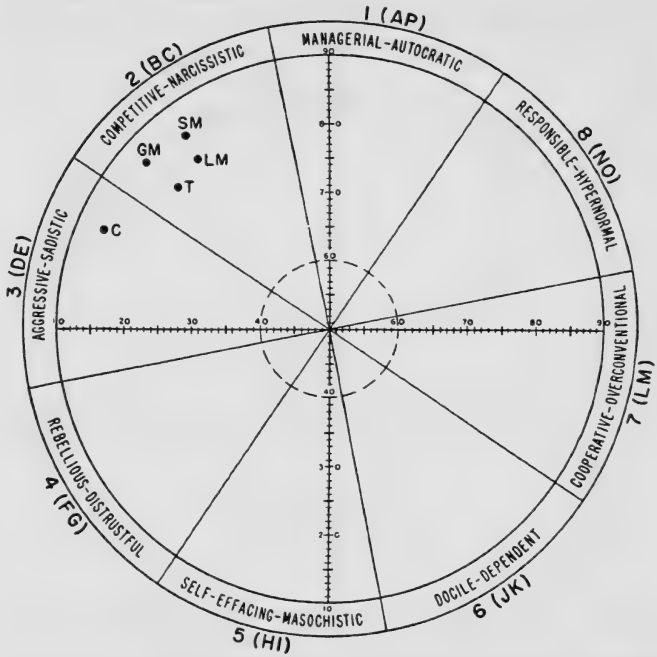


FIGURE 52. The Perceptions *of* the Production Manager by His Three Colleagues and the Consulting Psychologist. *Key:* The Production Manager as seen by:

SM = Sales Manager
LM = Personnel Manager
GM = General Manager
C = Psychological Consultant
T = Pooled scores of all four

hierarchy lead him to accept the General Manager as boss. Thus an uneasy but effective relationship was maintained. It is clear that the best relationship the Production Manager has is with the General Manager. If anyone is going to get close to the Production Manager and relax his tough, hard-headed approach, it is going to be the General Manager—and not the other two men.

(2) The Production Manager is involved in a sadistic relationship with both the other two executives. They both fear and hate him. The Sales Manager rebelliously fights back but can be provoked to irrational resentment by the Production Manager's calm, punitive scorn.

(3) The Personnel Manager masochistically submits to the Production Manager. The latter's unsympathetic hardness made him

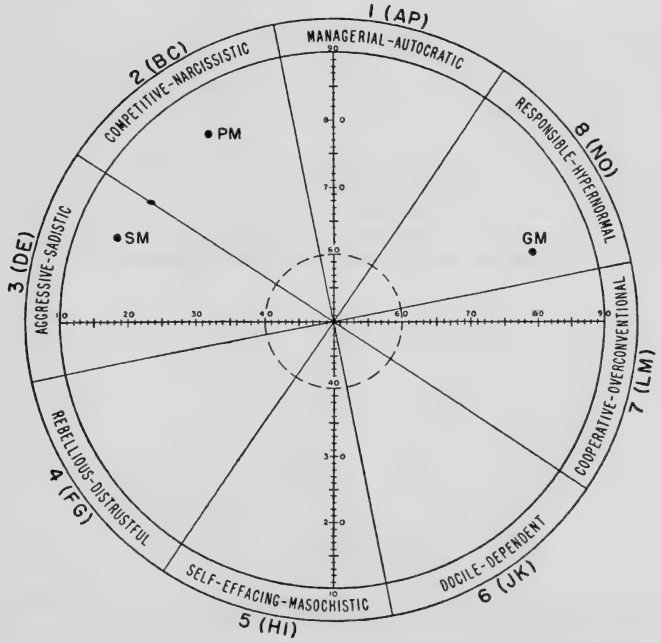


FIGURE 53. The Perceptions *by* the Personnel Manager of His Three Colleagues.

Key: GM = The Personnel Manager's description of the General Manager
PM = The Personnel Manager's description of the Production Manager
SM = The Personnel Manager's description of the Sales Manager

more self-effacing and timid. The Personnel Manager was comforted, however, by his slavish devotion to the General Manager—who protected him. The Sales Manager was isolated in impotent rebellion, having no positive relationship in the group.

The Personnel Manager

The Personnel Manager was a cheerful, bland, rather dull person. Placating conformity to strength and friendly sympathy to subordinates were his major security operations. He was fairly successful in his work because of his popularity, and good humor. His relationships

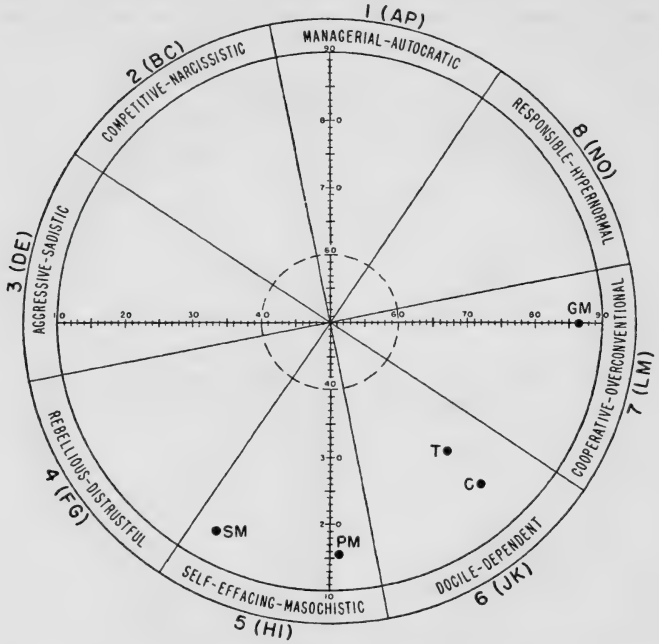


FIGURE 54. The Perceptions *of* the Personnel Manager by His Three Colleagues and the Consulting Psychologist. *Key:* The Personnel Manager as seen by:

SM = Sales Manager
GM = General Manager
PM = Production Manager
C = Psychological Consultant
T = Pooled scores of all four

with union officials were good because he was patient, agreeable and smiled when frustrated.

Figure 53 presents his perceptions of others. He admires the General Manager. He is in fearful awe of the two other men.

Figure 54 indicates that all raters see him as weak. The General Manager clearly likes him and an aura of good feeling blinds him to the Personnel Manager's submissiveness. The Production and Sales executives perceive him as weak, and sado-masochistic relationships exist with both.

The specific network of interactions involving the Personnel Manager has been presented in the previous discussions and need not be repeated.

Summary

Sociometric analysis of a top-level management group revealed that considerable psychopathology complicated and hampered relationships. The misperceptions and the rigid destructive symbiotic interactions prevented these men from clarifying or improving their relationships.

The psychologist was called in initially by the General Manager to consult about the Sales Manager's drinking. Sociometric analysis of the group dynamics quickly revealed that the drinking and rebelliousness of the Sales Manager was not an isolated symptom but intimately interwoven into the interpersonal fabric of the top-level group.

26

Predicting and Measuring Interpersonal Dynamics in Group Psychotherapy

The prediction of the individual's behavior in group psychotherapy was one of the first tasks approached by the interpersonal system (1). In Chapter 7 and in Appendix 1 the use of Level I-P indices as a forecast of the patient's future role is discussed.

Predicting the Resistance of the Group

These measures which forecast individual behavior have a further use in predicting the behavior to be expected from the group as a group. It has long been recognized that any group is more than an additive assemblage of its parts. When the Level I-Predictor scores of the constituent members are plotted on the same diagnostic grid, a network of interactions is apparent. It is possible to predict from this master grid what interpersonal operations will characterize this group.

After working with therapy groups for several years, the staff of the Kaiser Foundation clinic found that it was possible to describe the "personality" of a group; or to designate the group resistance. One group, for example, was anecdotally described as "slow and soggy"; another was labeled "bitter and resistive"; and another was called "centrifugal and lively."

Development of the Level I-S sociometric indices made it possible to objectify these clinical intuitions. In the "soggy" group, for example, five out of six patients were rated below the mean on dominance. Their passivity and lethargy were clearly defined by plotting all the Level I-S scores on the same group-diagnostic grid.

Development of the MMPI predictor indices made it possible to plot the expected role behavior of each member of a prospective group on a master grid. The therapist then could anticipate the type

of group resistance. If a large majority of the Level I-P scores fell on the left side of the circle, then a hostile, defiant, bitter group with plenty of interpersonal fireworks was forecast. If most of the scores fell on the right side, a friendly, sweet, repressive resistance to treatment could be expected.

Selecting Patients To Balance the Group Resistance

The introduction of the predictive indices and the methods for measuring group resistance made it possible to plot on group grids the members of some forty psychotherapy groups studied by the interpersonal system. The therapists of these groups were often able to detect from these charts the group resistance and to observe where imbalances in the group put intense pressure on the therapist which increased tension and lowered effectiveness.

Several large-scale studies of interpersonal behavior and changes during psychotherapy have been accomplished by the Kaiser Foundation research project. One conclusion reached is that the more imbalanced or homogeneous the group the less easy (and probably the less effective) the therapy. By this we mean that if a majority of the members of a group utilize the same interpersonal security operations, the task of the therapist is considerably complicated. If five members of a group are bland hysterics, they will tend to reinforce each other's reflexes; they will all like each other; they will all collaborate in denying and avoiding unpleasant emotions. The task of the therapist in facing a solid wall of group repression can be discouraging. The group joins together to put the same interpersonal pressure on the therapist. If, however, a wise-cracking psychopath, a colorful exhibitionistic narcissist, and a self-immolating masochist should be added, the pressure on the therapist is relieved. Intense interactions develop between the latter three and the hysterics. The therapist can sit back and observe, or intervene with technical activities without bearing the brunt of a unified resistance.

For these reasons the Kaiser Foundation clinic has initiated a procedure for selecting the members of a therapy group so as to provide a balanced combination of Level I security operations. Patients referred to groups by the weekly clinic intake conferences are placed on a waiting list. When eight to ten names are obtained the selection procedure begins. The Level I-P indices for all the patients on the waiting list are plotted on one diagnostic grid. The therapist can determine at a glance whether the candidates pile up in one sector or scatter around the circle. If the latter is the case, he selects two patients from each quadrant and these eight patients are assigned to the group. If the waiting list population is overweighted in one direc-

tion, the therapist postpones the group until more patients are referred to group therapy who fit the absent "slots." For example, if six out of the eight candidates fall below the horizontal line, a passive, dependent group is forecast. The therapist would immediately select the two strong candidates—then he would pick out four of the six passive patients and postpone the group until two more strong patients had entered the waiting list.

Selecting patients for group therapy thus becomes similar to the casting of characters in a play. The therapist by use of predictive indices attempts to set up a heterogeneous group in which interaction will be maximized.

Illustration of the Prediction of Group Resistance

Here is an illustration of the predictive indices employed to forecast group resistance. There were six members of this psychotherapy group. The Level I-P index of each patient before therapy was plotted on a master grid (see Figure 55). This group is well-balanced in respect to conventional versus unconventional operations—three members falling on either side of the vertical mid-line. The group is overweighted, however, on the dominance axis. Only one member is going to be passive—five are above the mean in dominance.

A noisy, power-oriented, self-confident set of reflexes can be anticipated. The group resistance is through strength and self-assurance. There will be a pronounced tendency for the members to lecture each other, debate, solve each other's problems, and compete for the role of group leader.

We can expect that patients "B" and "S" will bluntly press the others to express unconventional feelings. Patients "C," "P," and "U" will maintain a façade of "hypernormal" control and reasonability. Patient "M" will be isolated in his passivity and sit on the side lines. She is the only member to fall below the center line.

This group will not emphasize (in the early sessions) the presentation of problems. There will be a minimum of dependent, helpless behavior. If the therapist attempts to intervene, he will find himself in a power struggle. The one area of potential interaction is the difference in conventionality. Patients "B" and "S" will attack and challenge the others to produce negative feelings (with which they feel comfortable). Patients "P" and "U" will take on strong, executive roles. Patient "C" will stress hypernormal activities and blandly resist the colorful maneuvers of "B" and "S." But all five of these patients will act decisively and strongly as though they know how the therapy should be run—two by blunt uncovering of feelings, one by repressive denial of feelings, two by a mixture of both.

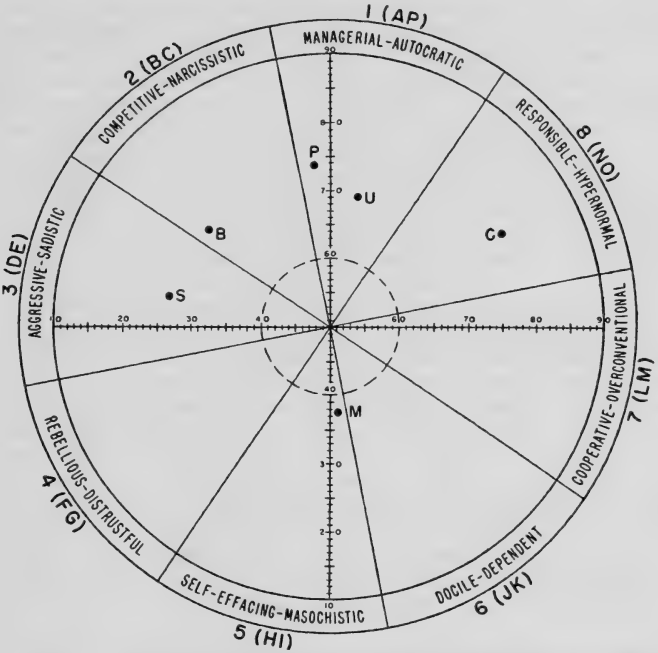


FIGURE 55. Predictions of Interpersonal Roles for Six Members of a Therapy Group.

Illustration of the Measurement of Group Resistance

After this therapy group had met for seven sessions, a sociometric was administered. Each patient rated himself and every other patient on the interpersonal check list. The ratings by the group of Patient "P" were pooled, the indices calculated, divided by five (N-1), converted to standard scores, and plotted on the diagnostic grid. The same procedure was applied to the group's pooled perceptions of each other patient. This is the Level I-S score—a summary of the social impact of each patient on his fellow members. These scores tell us how the patient acted in the group and can be compared with our original predictions of how the Level I-P indices predicted he would act.

Figure 56 presents the Level I-S scores for the six patients in this group. The Level I-P predictor scores are also plotted and linked to

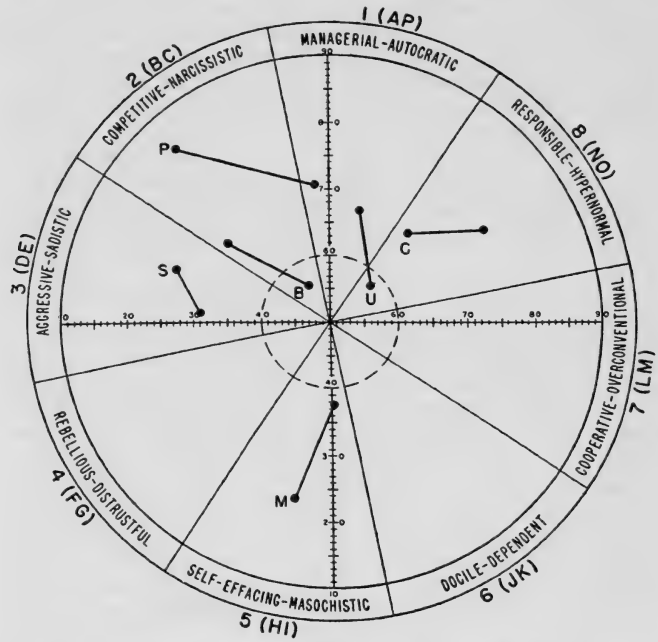


FIGURE 56. Measurements of Interpersonal Roles for Six Members of a Therapy Group. *Key:* Letter placements refer to Level I-S ratings of interpersonal behavior. The nonlabeled points to which they are joined designate the predictions of their role (Level I-P).

the Level I-S scores to indicate the amount of error in the prediction.

When we consider the over-all pattern of the Level I-S scores, it is clear that the original prediction of group resistance was fairly accurate. Four of the patients are rated to the left of the vertical mid-line, indicating that they were seen as more hostile than friendly. The prediction of group resistance was thus slightly in error on the love-hate axis. The forecast was more effective as regards to dominance-submission—since all six patients were rated on the side of the horizontal mid-line which matches the prediction.

Multilevel Reciprocal Interpersonal Relationships

Whenever a sociometric employing the interpersonal adjective check list has been given to the members of a group, it is possible to

plot the person-to-person network of relationships. There are two group-dynamics diagrams drawn up for each member using the printed booklet which was introduced in the preceding chapter. One of these indicates the subject's perceptions *of* every other member. The second indicates how the subject is seen *by* each other group member. Misperceptions, reciprocal role relationships, pairings, and isolates become easily apparent on these grids. This procedure for analyzing group dynamics was followed for the therapy group being described in this chapter. The use of these diagrams in understanding blocks and projections which complicate interpersonal relations has been illustrated in Chapter 23 (the management group) and need not be repeated in the case of this therapy group.

There is, however, an additional technique for analyzing group dynamics which involves the use of multilevel personality indices. These methods are more applicable in studying therapy groups (rather than industrial management groups) because measurements of underlying feelings are available for the psychotherapy patients and because the group therapy situation is more suitable for discussion of deeper motivations.

This more complex analysis of multilevel interaction patterns is accomplished by plotting the patient's scores for Level I and II Self, Mother, Father, and Ideal and Level III Hero and Other on the same diagnostic grid with his perceptions of his fellow group members, With these data available, it is possible to determine what meaning the perceptions of any specific group member has in relation to the eight scores from the subject's personality structure.

If the subject sees a fellow group member as being close to his own self-perception he is consciously identified with him.

If he sees a fellow group member as close to his ideal, he is considered to idealize him.

If he sees the other as close to his mother—the process of maternal equation is indicated. The proximity to father or spouse scores is similarly interpreted.

If the subject perceives a fellow group member as being close to his own Level III Hero—a cross-level identification is defined. That is, he projects onto or attributes to the other member his own "preconscious" feelings.

The relationship pattern of the group is thus related to the familial pattern and to the patient's preconscious imagery.

To illustrate this technique for analyzing multilevel reciprocal relationships we shall consider two patients in the sample therapy group who became locked together in a complex network. Figure 57 presents diagnostic grids for two patients "M" and "P." On each diagram

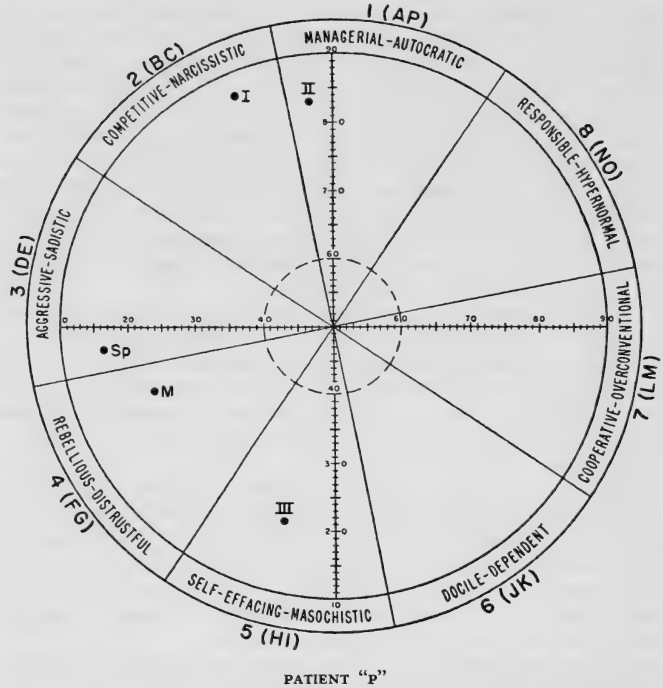
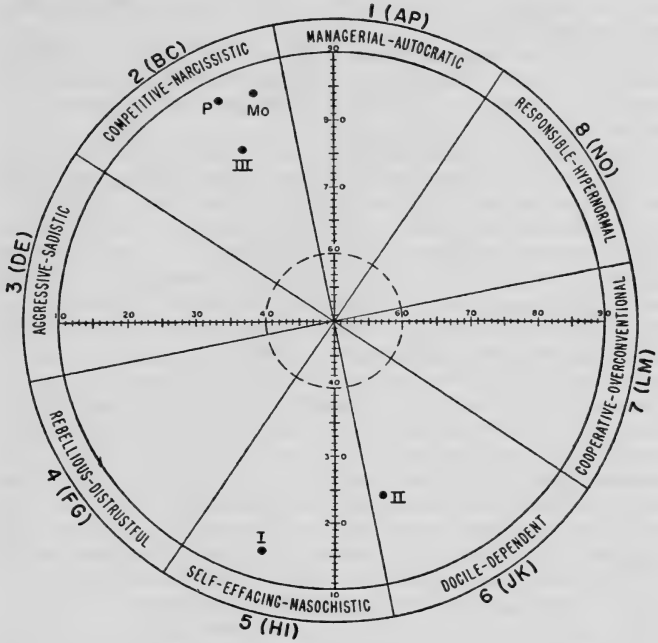


FIGURE 57. Illustrative Diagram of Five Measures of Personality for Two Group-Therapy Patients. *Key:* For both patients I = Level I-S; II = Level II-C Self; III = Level III-T Hero. For Patient "P," Sp = Husband; "M" = "P's" perception of "M." For Patient "M," Mo = Mother, "P" = Patient "M's" description of "P."

we have plotted five indices: four personality scores for the patient and his perceptions of the other one. For didactic purposes, we have omitted the other four personality scores and the patient's perceptions of the other group members. For Patient "P" we have tallied the scores for Level I-S Self, Level II-C Self, Level II-C Spouse, the Level III-T (Hero) and the perception by "P" of her partner "M." For Patient "M" five scores are plotted: Level I-S Self, Level II-C Self, Level II-C Mother, Level III-T (Hero) and Patient "M's" view of "P."

Consider the diagram for Patient "P." She sees herself (II) as independent and forceful. She is seen by the group (I) somewhat the



PATIENT "M"

same way, although they see more competitive narcissism. She maintained an aloof, cool, poised superiority in the group—never admitting any faults or weaknesses. She continually patronized the other patients, looked down on their problems and smugly beat off any attempt to prove she was not "right, wise, and capable."

She described her husband (Sp) as being a rebellious, bitter man. Actually she was in the group because of a marital problem. Her husband drank, gambled, and beat her in drunken rages. Her stated reason for accepting group therapy was to understand herself, her role in the marriage, and to learn how "to handle" her husband more effectively.

The deeper reasons for her marital problems are suggested by her Level III-T score. Masochism and guilt saturate her "preconscious" fantasies. Her smug, righteous, superior façade pushed her husband to bitter, delinquent rebellion and to wild retaliating rages. The pun-

ishment she took from him seemed related to her underlying self-punitive, guilty feelings.

We are particularly interested in Patient "P's" relations with Patient "M." Figure 57 indicates that she perceives "M" as being resentful, complaining and rebellious. She consciously equates "M" with her husband.

Consider now the diagnostic grid for Patient "M." She sees herself (II) as a docile, weak, self-punitive person. She is seen by the group (I) as exhibiting a similar slightly more masochistic role. Actually this summary score for Level I is the resultant of two somewhat different perceptions the group members had of her. Some members saw her as helpless, weak and dependent. Two members saw "M" as resentful and complaining. We recall that Patient "P" was one of these. Patient "M" spent most of her time in the group describing her failures and shortcomings—as a wife, mother, neighbor, housekeeper, etc. She continually blamed herself for not meeting her own inordinately high standards. In responding to other group members (except "P"), she tended to be a silent listener—never advising or attacking. Her relationship to "P," however, was quite different. She continually nagged "P" to present her problems, accused "P" of being smug, challenged "P's" bland denial of problems. Considerable electricity was in evidence when these two interacted. Most of the other members were admiring or abashed or helplessly overwhelmed by "P's" superior role—in contrast to "M's" irritated needling of "P."

This relationship is objectified in "M's" perception of "P" in Figure 57. She describes "P" as cold, arrogant and narcissistic.

Patient "M" sees her mother in the same way as she describes "P." As her case history unfolded in the group it became clear that "M" was bitterly entangled with her mother. She described her mother as a bossy, righteous person with fanatic standards of virtue and obedience who never admitted to any failure. Her mother's punitive coldness had intimidated "M" for many years and she was still loaded with fear, guilt and resentment towards her mother.

Patient "M's" Level III also falls in the narcissistic sector of the circle. This indicates that she was "preconsciously" identified with her mother's strength and hostility.

It is now possible to fit together the multilevel of the two patients and to observe the neat dovetailing of narcissistic and masochistic conflicts.

Patient "P" was an overt narcissist with underlying guilt and masochism. Her overt smugness provoked angry rebellion from her husband and from "M." Her original question which led to her therapy was: "Why does my husband resent me?" It was answered in

part by her effect on Patient "M." The latter expended considerable energy in battering away at "P's" façade and eventually stimulated and led a revolt of the group against "P." A second answer to "P's" question is supplied by her own "preconscious" feelings. It eventually became clear that "P" had deep feelings of shame, guilt, and inferiority. She had remained in a most unhappy marriage for over two years, supporting her husband, accepting his beatings, paying his gambling debts, nursing him through hangovers because of her underlying feeling that she deserved no better.

Patient "M" was on the other hand an overt masochist with underlying feelings of moral superiority and narcissism. She had always identified herself ("preconsciously") with her mother's cold, harsh righteousness and overtly suffered in order to maintain the inner commitment to these standards. The original question which led her to seek treatment was: "Why do I feel depressed, guilty, and weak?" This was answered in part by her reaction to "P." Patient "M," we recall, was the first group member to spot "P's" superiority and reluctance to act like a patient with problems. Therapists who work from the interpersonal viewpoint are always alert to pick up and focus on relationships of this sort. It became clear that "M" was extremely sensitive to "P's" behavior because most of her energies were tied up in her ambivalence towards her mother. A second answer to "M's" question is furnished by her own underlying feelings—which indicated an identification with her mother's superior standards.

Patient "P" served as a most therapeutic figure for "M." "P" served as a magnet pulling from "M" the intensely conflicted feelings which created her neurosis. "M" transferred to "P" her perception of her mother and relived in the group the crucial, embattled relationship.

Patient "M" was an extremely valuable figure for Patient "P." "M's" sensitive radar picked up "P's" irritating, patronizing superiority and made it clear to the other members and eventually to "P" herself. When "M" attacked and complained about "P," she reproduced in the experimental subsociety of the group the problem which was destroying "P's" marriage and wrecking her life.

This paired pattern of multilevel projection, misperception, identification, and role-reciprocity locked these two patients in a complex relationship. The analysis of this relationship reached close to the roots of both patients' conflicts.

Other patients in this group became entangled in multilevel relationships which were equally complicated. Another naïve, ultraconventional member ("C") became engaged in an intense conflict with a rebellious psychopath ("S"). The friction between these two pro-

vided clues and an observable experimental repetition of the multilevel conformity-rebellion problems that both shared.

In these illustrations we have attempted to demonstrate the usefulness of the interpersonal diagnostic system in understanding multilevel reciprocal relationships as they occur in group psychotherapy. Two of the four major applications of the interpersonal system have been brought to bear on this problem—its use as a multilevel diagnostic instrument and its use as a tool for analyzing group dynamics. The group psychotherapy situation serves as a unique testing ground for the rudimentary techniques of the present and as a developing ground for the improved techniques which we know must follow.

This volume is concluded with no sense of completion or closure, but with an impatient dissatisfaction resulting from the many limitations of these shaky initial steps. It is fitting that we terminate—perhaps abruptly—in a discussion of the complexity of multilevel relationships in psychotherapy. This serves, at least, to point the course towards the two problems which are currently engaging the energies of the Kaiser Foundation research project: a study of the interlevel mechanisms of personality organization and the measurement of changes in personality during psychotherapy.

Reference

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Appendices

1

Illustrations of the Measurement of Interpersonal Behavior at Level I

This chapter presents the detailed methodology for obtaining four different Level I scores. First we shall illustrate the derivation of MMPI symptomatic indices (Level I-M). Next we shall consider the Level I-P indices which forecast interpersonal behavior to be anticipated. Then we shall follow two sample patients (a typical ulcer patient and a severe neurotic) in the initial minutes of a recorded group therapy session. This will illustrate the technique for obtaining Level I-R ratings. This will be followed by a description of the Level I-S indices for one of these patients and an illustration of the method for calculating these sociometric indices.

Illustration of the Level I-M Predictive Indices

During the initial diagnostic and evaluation period every new patient reporting to the Kaiser Foundation psychiatric clinic is administered the complete interpersonal test battery, including the MMPI. The intake conference uses all the available clinical information, in addition to the test material, to make recommendations for type of treatment.

In this section we shall describe a method for making interpersonal predictions from the Minnesota Multiphasic Personality Inventory.[1] These procedures are part of a larger study in interpersonal diagnosis in which we are attempting to develop MMPI indices which predict

[1] The Minnesota Multiphasic Personality Inventory comprises nine clinical, psychiatric scales and four validating scales. These are entitled as follows: Hs = hypochondriasis; D = depression; Hy = hysteria; Pd = psychopathic deviate; Mf refers to masculinity-femininity tendencies; Pa = paranoia; Pt = psychasthenia or obsessive tendencies; Sc = schizoid tendencies; Ma = mania. F = a tendency to answer items in a statistically deviant manner; K = a tendency towards a defensive denial of psychopathology;? = items questioned or unanswered; L = a tendency to falsify or to answer in a socially acceptable way.

to different levels of interpersonal behavior. Other MMPI indices are being developed which predict to conscious, "preconscious," and value levels of personality.

We have seen in Chapter 6 that the interpersonal diagnostic circle can be viewed as a two-dimensional surface in which points are located in reference to the vertical (i.e., dominance-submission) and horizontal (hostility-affiliation) axes. The interactions of any subject can be converted into the horizontal and vertical tendencies, thus providing a single summary point.

In attempting to convert the MMPI into an instrument for predicting interpersonal behavior, the same procedure was followed. Two years' experience in comparing MMPI profiles with interpersonal profiles provided many clinical cues as to the relationship between the two. These cues were tested in a series of pilot studies sortings on several hundred cases (1). These exploratory procedures suggested that eight of the MMPI scales were related to the role behavior of patients seen in the clinic. Four of the MMPI scales—Ma, D, Hs, and Pt—seem to be correlated with dominant-submissive behavior. Four other scales seemed to be related to friendly-hostile behavior. These are Hy, Sc, K, and F. The absolute height of these scales then taken by themselves has a varying prognostic value; some have low correlations with interpersonal behavior; others are surprisingly high. When the general pattern of their interrelationship was studied, significant predictions resulted.

The first set of indices for predicting dominant or submissive interpersonal behavior are:

Ma — D: If Ma > D, a + score results. This indicates that interpersonal strength, assertion, and confidence are emphasized. If Ma < D, the opposite is indicated. Weakness, immobilization, and lack of confidence are suggested.

Hs — Pt: If Hs > Pt, a + score results. The subject seems to be indicating that his physical health concerns him more than emotional worries. This is the wounded-warrior theme often expressed by psychosomatic patients. The subject admits to some bodily weakness, but emotional strength is by comparison stronger. If Hs < Pt, the opposite is true. The subject is more concerned with his emotional problems and is emphasizing fears, worries, or immobilization.

For predicting affiliative or hostile behavior four MMPI scales are combined as follows:

K — F: If K > F, the subject tends to present himself as a helpful, friendly, outgoing person. If K < F, the patient tends to

be judged as alienated, disaffiliative, rebellious, unfriendly. A positive score on this index thus pulls toward the right or friendly side of the circle; a negative score in the hostile direction.

Hy — Sc: In this index the same trends appear. High Hy scores correlated with bland, naïve, superficially agreeable behavior; high Sc scores with isolated hostile roles. Thus a positive score on this index pulls to the right and a negative score to the left of the circle.

In this manner eight MMPI scores [2] can be converted into vertical and horizontal indices and translated into the language of the interpersonal system. Four scales—Ma, Hs, D, and Pt—when pooled yield a vertical (dominance-submission) factor, and four other scales—K, Hy, F, and Sc—yield a horizontal (love-hate) factor. When the vertical and horizontal factors are plotted on the two-dimensional surface of the interpersonal circle, a summary point is obtained which becomes the prediction of future role interactions. Later correlational studies, which are presented elsewhere (1), have suggested that other combinations of MMPI scores may yield more effective predictions. Cross-validation studies on the new formulas have not been accomplished at present. The current findings (clinical and correlational) have demonstrated that the eight scales described above with certain qualifications perform adequately in assessing the interpersonal meaning of the patient's symptoms. The formulas which have just been presented yield scores which are designated Level I-M.

After these MMPI symptomatic indices were obtained, the next step was to standardize them. The standardization sample chosen was the entire intake population of a psychiatric clinic over a two-year period. The 787 cases which comprise this sample may be divided into two clinical groups roughly equal in size—those referred by physicians for psychosomatic symptoms, and self-referrals. The MMPI was routinely administered to all the patients who were evaluated by intake procedures.

The two MMPI indices (horizontal and vertical) were standardized so that the indices for each patient can be expressed in terms of their distance from the mean of the total sample.

It is thus possible to plot each patient's Level I-M scores on the interpersonal diagnostic grid and to indicate the intensity and type of the predicted behavior. The center of the circle was determined by the means of the horizontal and vertical distributions. The distance and direction from the center of the circle automatically "types" the Level I symptomatic behavior in terms of the sixteen variables.

[2] In all of the MMPI indices the K-corrected standard scores are employed.

By way of illustration, let us consider two MMPI profiles of male patients. The solid line in Figure 58 indicates the MMPI pattern of a patient who came to the clinic complaining of neurotic symptoms—immobilization, depression, and marital discord. The dotted line indicates the record of an ulcer patient referred by his physician for psychological evaluation. Table 38 shows interpersonal conversions of the MMPI profiles. The standard scores used in the formulae are located on the extreme left and right hand sides of the profile sheet, labeled "T or Tc."

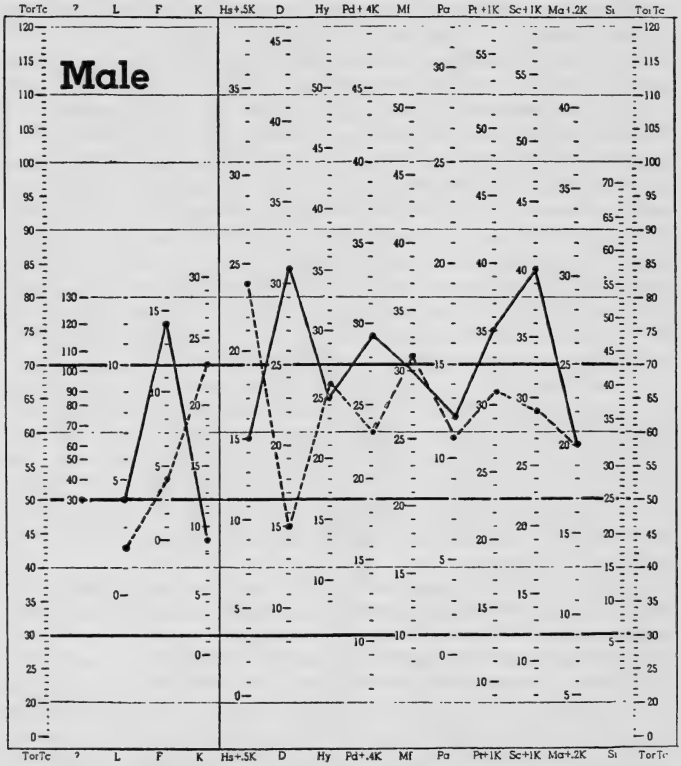


FIGURE 58. MMPI Profiles on a "Classic Neurotic" Patient (Solid Line) and an Ulcer Patient (Dotted Line).

TABLE 38

ILLUSTRATIVE CALCULATION OF MMPI INDICES FOR MEASURING SYMPTOMATIC BEHAVIOR (LEVEL I-M)

MMPI Index	*"Neurotic" Patient (Male)*	*Ulcer Patient (Male)*
Ma − D	58 − 84 = −26	58 − 46 = +12
Hs − Pt	59 − 75 = −16	82 − 66 = +16
Vertical total	−42	+28
Vertical total converted to standard score	43	72
K − F	44 − 70 = −32	70 − 53 = +17
Hy − Sc	65 − 84 = −19	67 − 63 = + 4
Horizontal total	−51	+21
Horizontal total converted to standard score	33	60

The horizontal and vertical scores for these two patients were then plotted on the standardized diagnostic grid.[3] (See Figure 59) The resulting summary points indicate that entirely different interpersonal behavior can be expected from these two patients. The neurotic's MMPI predictive indices for Level I place him in the octant *FG*. To the extent that the MMPI conversions hold good, we should anticipate sullen, rebellious, and passively hostile behavior. The ulcer patient falls into the octant *NO*—thus we can expect that responsible, strong, and helpful behavior will develop. The neurotic patient will complain of symptoms in a passively coercive manner. The ulcer patient will probably manifest no overt hostile, dependent, or weak behavior.

These symptomatic indices have become the standard Level I diagnostic tool *for the psychiatric clinic*. At the time of intake evaluation, the symptomatic pressure exerted by the patient is of crucial importance in planning a therapeutic program. All of the diagnostic studies reported in Chapters 15–22 employ Level I-M measures.

These indices do not work as well in other functional settings. They would not be used, for example, to predict behavior in an industrial office or in group discussion situations. The subject's emotional *symptoms* are not the crucial factors determining behavior in these environments.

When Level I-M indices are correlated with sociometric ratings of group behavior (Level I-S), the relationships, while significantly positive, are not high enough for use in predicting roles in group psycho-

[3] The standard score conversions of Level I-M which are employed in the diagnostic grid of Figure 58 are based on a sample of 787 psychiatric clinic patients. The mean of the vertical distribution (i.e., Ma − D + Hs − Pt) is −24.4, and the sigma is 24.1. The mean of the horizontal distribution (i.e., K − F + Hy − Sc) is −6.13, and the sigma is 27.1. A table for converting Level I-M dominance and hostility indices into standard scores is presented in Appendix 5.

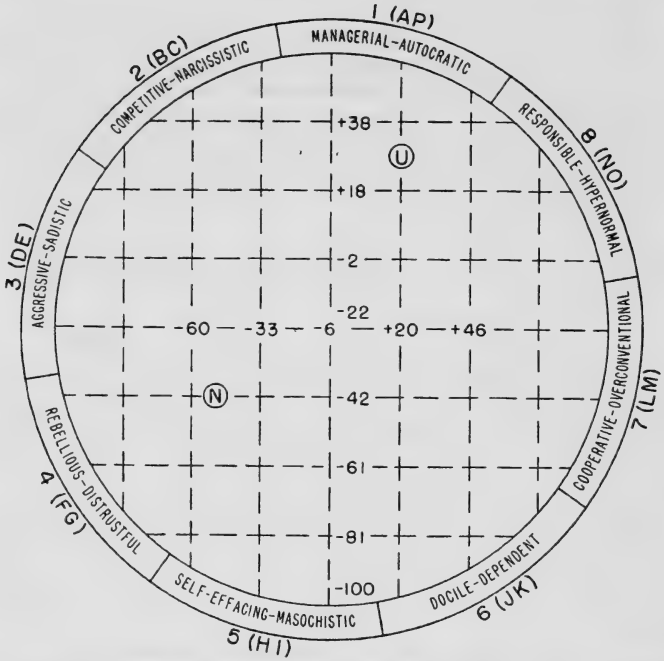


FIGURE 59. Diagnostic Grid for Locating Level I-M Diagnosis. *Key:* The center of the circle represents the mean score of the horizontal and vertical distribution (standard score of 50). Each calibrated line on the grid equals one standard deviation. To locate the predicted interpersonal role on the circular grid: (1) Determine the horizontal and vertical indices, from the MMPI formulas. (2) Locate the horizontal coordinate and the vertical coordinate on the major axes of the diagnostic circle. The major axes are calibrated so as to convert the raw MMPI indices into standard scores. (3) The position where these intersect determines the predicted interpersonal role. The farther from the center, the more extreme and maladjustive the symptomatic pressure exerted by the subject. The two illustrative cases whose indices were calculated in Table 38 are plotted on this grid. Ulcer patient = U, and the patient with classic neurotic symptoms = N.

therapy. This means that Level I-M indices which work well at the intake diagnostic level are less useful in predicting how the patient will behave in group therapy.

Level I-P Indices for Predicting Behavior in Group Therapy

The limitations of the Level I-M indices made it necessary to develop improved methods for predicting behavior in group therapy.

Two criterion-specific MMPI scales (one for dominance and one for love) have been developed which predict role behavior in groups. These provide the Level I-P diagnosis. Each of the 550 MMPI items was studied to determine its relationship to I-S dominance-submission and love-hate. The items which discriminated the Level I-S vertical factor (at a level of statistical significance) were combined into a Level I-P index for dominance. A scale was also constructed which relates to the horizontal (hostility) factor. These scales are in the process of cross-validation.

Illustration of the Scoring of Interpersonal Reflexes from Group Therapy Interactions

The most straightforward method of coding interpersonal reflexes is to rate the blow-by-blow interaction sequence—either observed directly or followed on electric recordings or typed transcripts.

The two sample patients (ulcer and severe neurotic) whose predictive indices were calculated in the previous section were assigned to the same therapy group.

We shall now present a transcription of the first few minutes of the initial group therapy session. The severe neurotic patient described above is coded "SN" and the classic ulcer patient, "ULC."

In this passage the interpersonal reflexes are scored at the right. The scoring of each mechanism consists of three ratings: the code letter representing the location of the action along the circular continuum of interpersonal mechanisms, the verb considered most closely descriptive of the action, and the rating of intensity of the mechanism along the four-point scale. In practice, the scoring of the descriptive verb may be omitted.

GROUP THERAPY PROTOCOL

Six male patients file into a room and seat themselves expectantly. One patient, SN, glances at a picture on the wall of the therapist's office and begins the group therapy process by remarking:

			Mechanism or Reflex	*Code*
1	SN	Is that suppose to be art on the wall, or is that something somebody drew in the hospital?	Ridicules	*D-3*
2	Th	Now, the purpose of our meeting in general is to help each of you to come to a better understanding of yourself, a deeper understanding of yourself. The meetings will last about an hour and a half, we'll meet for at least four	Teaches	*P-2*

			Mechanism or Reflex	*Code*
		months, at least 15 or 16 times. [Therapist continues structuring for two minutes.]		
3	Th	. . . I'm going to throw the burden of the conversation now to the group. I'd like to have you tell yourself and tell us, today and for the next few days, who you are, why you see yourself coming here and what you might want to get from the group.	Directs	*A*-2
4	SN	What if you don't know? What if you haven't the slightest idea what you want?	Passively resists	*F*-3
5	Th	Well, that's a good place to start. You have already told us something interesting about yourself.	Supports	*N*-2
6	SN	How can you talk about something you don't know anything about?	Passively resists	*F*-3
7	EE	We could have a sympathizers' club here.	Ridicules self and others	*H*-1 *D*-1
8	AA	A friend of mine suggested that, as a matter of fact.	Agrees	*L*-1
9	SN	Is that it? Are we supposed to cry on each other's shoulders? Is that the object of it? Crocodile tears and sympathetic ears, is that the idea?	Passively resists	*F*-3
10	Th	(smiles) I hope we can help each other more than just by groaning together.	Ridicules	*D*-2 *I*-2
11	EE	Mr. SN has said . . . I felt that way too about knowing what I want, but I think that's more a problem of just . . . ? . . . or you've just gotten so darn discouraged about things you just don't . . . well, there's a feeling, I know with myself . . . feeling that what a lot of people want just aren't worth a candle, that's all . . . it seems to take too much out of me in the way of effort and emotional drive or something.	Takes weak position	
12	Th	You don't just want the things that any other people want?	Summarizes	*P*-2

			Mechanism or Reflex	*Code*
13	EE	Yeah, I seem to have gotten into an attitude of what you might call emotional dumbness where I don't just seem to have the emotional level that some people have. Some people get enthused about going to a picnic, ball game or this, that and the other thing . . . I mean, speaking for myself, I'll say, "Ah, just let me alone." If somebody's going to a picnic, I don't give a damn whether they go to Milpitas, San Francisco or what not. I don't expect to enjoy myself at a picnic. I'd rather stay home and sit on my butt and thumb through a magazine or something . . . keep comfortable and not bother with anything.	Condemns self	*H-3*
14	ULC	You're speaking generally now—not just about a picnic? About many things . . . Because I was going to say, there are a lot of people who take that attitude about certain things. You can never get them to work up enthusiasms to get them to do anything, and yet they have other outlets, or are enthusiastic about . . .	Explains	*P-3*
15	EE	Yes, about a lot of things . . . like, for example, a good deal of my problems center about my work. I kind of rationalize that by saying, "Oh, to hell with it! Most things people do aren't worth doing anyway." I repair air conditioners for a living, for example. I have a very bad attitude about the sets. Firstly, I can't sympathize with my customers. I don't see why they want to keep the damn things going. (laughs) And, they hound me to get the work. Of course, with my attitude, one could make a virtue of it. You could say that I have infinite patience. Frankly, I don't care. I'm not anxious to get paid, I'm not anxious to get started, I'm not anxious to finish. In fact, I feel a good deal of anxiety frequently about getting started and I think that's part of Mr. SN's . . . that there's something there—a counter	Depreciates self Pulls for sympathy	*H-3* *J-3*

			Mechanism or Reflex	*Code*
		force. It isn't that a person doesn't know what they want to do, really. I mean that there's some counter force that makes anything that you want to do not worth the price. (He continues at length in this vein.)		
16	EE	. . . they feel that I don't have a damn bit of interest in their particular problems and even though my proposition is reasonable . . . in many cases I've gotten turned down. I had an example of that recently. By the way, am I taking up too much of the time?	Accuses, describes self as exploited Mildly criticizes self	*G*-3 *H*-1
17	Th	Let's stop a minute because you have raised several interesting themes, the feeling of obligation, the feeling of being pressed in on by forces that . . .	Directs Summarizes	*A*-2 *P*-2
18	EE	Like when I rest . . . like last night when my wife says "Well, do you want to go out tonight?" I have already complained about being tired and I did feel tired. It was about eight-thirty that I started out.	Accuses others Passively resists therapist's direction	*G*-3 *F*-3
19	Th	Somewhat against your will, but you did go.	Reflects	*O*-2
20	EE	That's right.	Participates	*L*-1
21	Th	Now let's stop for a moment. Have these themes made anything click as you've listened to EE describe them?	Directs	*A*-2
22	SN	The idea of the annoyance of being pressed is common. That's common to everybody, isn't it? When you get somebody on your tail and you know that they are right and they have justification in their claims and that you can't satisfy them or . . . and then you feel a negative attitude . . . you would like to take their work and throw it out.	Gives opinion	*P*-2
23	Th	What do you usually do when you feel that . . . do you throw their work out?	Therapeutic question	*O*-2
24	SN	No, you just smile, and say, "Oh, that's too bad."	Depreciates self	*H*-2

			Mechanism or Reflex	*Code*
25	Th	Is that what you usually do?	Therapeutic question	*O*-2
26	SN	Well, sometimes I sort of digress a little bit and I carry on a little campaign trying to impress people that there is a lot more to it . . . that they are expecting more. . . .	Mildly praises self	*B*-1
27	Th	But you've never been in that position.	Summarizes	*P*-2
28	SN	Never been in that position. Sometimes I've wanted things and the next day I got them and it seems as though when I got them it wasn't what I wanted after all.	Feels disappointed	*G*-2
29	Th	What have your thoughts been as you have listened?	Calls	*A*-2
30	ULC	Well, first of all, Mr. SN's statement of enthusiasm, followed by a period of less enthusiasm or depression, according to my understanding is more or less normal to a certain degree, now if that goes to a greater degree, maybe that's not normal. All of us have periods where we work easily and enjoy our work. Now whether it is during that period you also suffer some of that anxiety you said you worried about the periods that are coming. . . .	Pedantically teaches	*P*-3
31	Th	How do you compare with SN or EE as they have presented their situation?	Therapeutic question	*O*-2
32	ULC	Well, it didn't quite fit in exactly. My work is a little different and I don't have to meet the public. I'm a . . . and as such I work under the directorship of the department head, the group leader, so that, while we have pressure on us at times to do work, it isn't the idea you're worrying about the business ahead, or discouraging customers.	Denies problem	*B*-2
33	BB	Do you worry about your work coming out right? Does that give you anxiety feelings?	Therapeutic question	*O*-2
34	ULC	I think . . . is very frustrating in one respect and that is that it seems like ninety percent of the time or greater	Describes frustration	*G*-2

			Mechanism or Reflex	*Code*
		your . . . what you do does not come out in a favorable manner. In other words you are only looking for the few successful experiments. That's what makes the money for the company. You have volumes and volumes of papers describing work you did that no one will ever look at again.		
35	BB	Does that worry you—your relationship with your immediate superiors? Do you feel that maybe you haven't done things right or fast enough or careful enough?	Therapeutic question	*O-2*
36	ULC	Yes, you do have those feelings too, that's true.	Accepts	*L-2*
37	EE	Well, I think there's a sort of tie in that basically it is simply probably you don't meet the general public so much as that your problems center maybe on one or two individuals.	Gives opinion	*P-2*
38	Th	Have you had this feeling of pressure that SN or EE have described?	Therapeutic question	*O-2*
39	ULC	No, not too much. No.	Denies problem	*B-2*

This passage serves as a nice illustration of the development of interpersonal reflex patterns. The opening moments of a psychotherapy group are always most dramatic and important. Six strangers come together, meet for the first time, and begin automatically to train each other. The network of interaction, perception and misperception begins to weave itself. Consider Patient "SN" in the above passage. In the first five seconds of the group he has launched a critical and skeptical arrow. He challenges the therapist sarcastically, asking about a Picasso print on the wall. We may suspect that through these comments he is telling not just the therapist but the group in general, "I'm a negative, uncooperative person; you're going to have trouble with me." We have no record of what the five other patients were doing while Patient "SN" was making his opening gambit. A motion picture record might have revealed that the others were, in their own way, beginning to develop their roles. Patient "ULC" who later expresses himself verbally as a self-satisfied, executive person might very well have been using non-verbal means to communicate his detached competence—crossing his legs briskly and shooting alert glances

around the room. Patient "EE," who is soon to begin building a façade of self-critical weakness may, in these opening seconds, have been sending sheepish, apprehensive glances towards the others.

As we follow the subsequent moves of the grumpy Patient "SN" we see the same reflex pattern unfolding quite consistently. Interactions #6 and #9 continue to communicate the theme of uncooperative and passive resistance.

As Patient "EE" enters the action (remarks #11 and #13) a different set of reflexes appear. Patient "EE" begins a sequence of passive self-effacement. His self-depreciatory remarks are continued at length in #15 and we sense that by #16 that they have developed into a repetitious circle of pessimistic ruminations. He apologizes for monopolizing the discussion. Interactions #17 and #18 focus on a most interesting transaction. The therapist (#17) attempts to check the flow of anxiety-driven words, but "EE" (in #18) continues his reflex laments. In ignoring the therapist's intervention, "EE" provides us with a nice illustration of the involuntary nature of Level I communication. We may safely guess that this patient did not deliberately or consciously interrupt and disregard the therapist. He has just expressed conscious anxiety about talking too much, but automatically goes on to produce a rather flagrant example of insensitive, anxiety-driven complaint.

At this point, it will be seen that Mr. "EE" has engaged in seven interactions (#'s 7, 11, 13, 15, 16, 18, and 20). What impression can we surmise he has made on his fellow group members? On the therapist? These six communications provide the data for a small experiment in interpersonal relations in which the reader may participate. Glance back over Mr. "EE's" statements, imagining that you are a member of this therapy group. What feelings do you sense in response to his comments? Some readers have reported a feeling of sympathy, mixed with superiority, and irritable impatience. To the extent that these feelings have been aroused in the reader then to that extent "EE" has in seven easy steps taught or trained the reader to respond to him in a typical and consistent way. Mr. "EE" had an unusually rigid and inappropriate set of reflexes—apologetic, self-critical, and complaining. He trained the group members and the therapist just as he had trained everyone in his life to respond to him with tolerant and/or irritable superiority.

This set of reflex responses seemed to operate as a defensive maneuver. Occasionally he was able to show other responses. But the more anxious he became, the less able he was to respond appropriately and the more driven he was to continue his interpersonal defenses (as illustrated clearly in the sequence #17 and #18).

It is possible to summarize the interactions during any given time period in a diagram. We simply count up the interactions for each subject and chart them on the diagnostic circle. The intensity of the interaction can be graphically illustrated by using different colors in the diagram (green for intensity 1, black for intensity 2, etc.), or by multiplying each score by the intensity (so that one F-3 would equal three F-1's). Using the latter technique, we have included a diagrammatic summary of the interactions of three of these patients in Figure 60.

During the first five minutes of this session, we see that Patient "SN" is rated as skeptical and passively resistant; Patient "EE" as

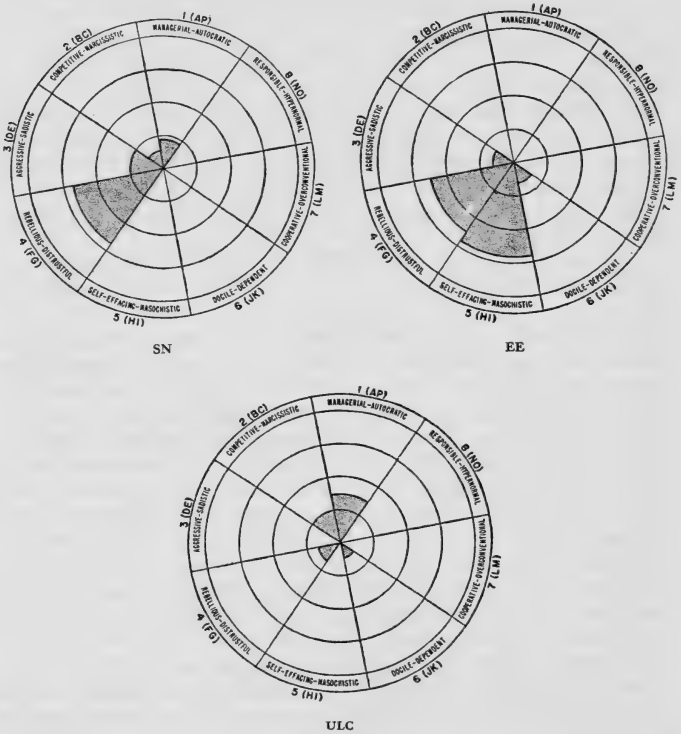


FIGURE 60. Summary of Interpersonal Behavior of Three Patients During First Five Minutes of Group Psychotherapy.

weak, self-derogatory, and passively resistant; while Patient "ULC" is rated as executive, strong, and self-satisfied.

Illustration of the Level I-S Index of Interpersonal Behavior

The preceding sections have followed two sample patients through two different measurement processes. The Level I-M scores summarize the interpersonal meaning of their symptoms. The Level I-R scores summarize how they actually did behave in the first minutes of therapy. We shall now describe another estimate of interpersonal role based on sociometric ratings.

After six sessions of therapy, each patient in the group was administered the Interpersonal Adjective Check List. Each subject rated his impression of every other patient in the group and was in the same way rated by all the members of the group.

The total number of items for each octant attributed to each member of the group by every other member was then tabulated. Table 39 presents these data for the severe neurotic patient whom we have followed in the previous discussions.

These figures have many uses. It is possible to diagram separately (either in raw octant totals or by means of trigonometric indices) the perception which each group patient has about Patient "SN." Interesting patterns of misperception become obvious. In this case it is possible to determine (from Table 39) that Patient "ULC" views Patient "SN" differently from the consensual perception of the group. He attributes more docility (*JK*) and tenderness (*NO*) to Patient "SN."

TABLE 39

ILLUSTRATION OF THE CALCULATIONS FOR DETERMINING THE LEVEL I PROFILE FOR A "NEUROTIC" PATIENT, SN

	Fellow Group Member Making Ratings of Patient SN					*Raw Total of Words Assigned by Group to SN*
Octant	*AA*	*BB*	*ULC*	*EE*	*FF*	
AP	4	4	3	2	2	15
BC	3	2	1	1	4	11
DE	10	4	2	4	10	30
FG	13	10	4	8	15	50
HI	14	8	13	11	14	61
JK	10	4	10	4	7	35
LM	4	1	6	2	3	16
NO	3	0	11	4	0	18
Total No.	61	33	50	36	55	235

When the raw octant totals are placed in the trigonometric formulas: Dom = −85.2; Lov = −19.6. When these indices are divided by the total number of words (235): Dom = −.363; Lov = −.083.

At this point we are concerned with the derivation of the summary Level I-S score. This is obtained from the calculations in the right-hand column of Table 39. Vertical and horizontal indices were calculated using the total number of words per octant assigned by the group to Patient "SN."

These horizontal and vertical indices are converted into standard scores by means of norms derived from large samples of group therapy patients. The horizontal and vertical standard scores become the Level I-S indices.

These can then be plotted on a diagnostic grid to determine the Level L-S diagnosis. The summary point for Patient "SN" locates in the extreme sector of the *FG* octant. The Level I-S diagnosis based on a consensual sociometric impression of fellow group members thus duplicates the Level I-R score.

Reference

1. Leary, T., and H. Coffey. The prediction of interpersonal behavior in group psychotherapy. *Psychodr. and gp. psychother. Monogr.*, 1955, No. *28*.

2

The Interpersonal Adjective Check List

The instrument routinely employed to measure interpersonal behavior at Level II-C, Level V-C, and Level I-S is the Interpersonal Adjective Check List. This measuring device has been designed by Robert Suczek, Ph.D., Rolfe LaForge, Ph.D., and the other members of the Kaiser Foundation psychology staff (1). It has been subjected to intensive empirical study over a period of five years and has gone through three major revisions.

The present form of the check list (Form IV) comprises 128 items —eight for each of the sixteen interpersonal variables. An intensity dimension has been built into the check list such that each of the sixteen variables is represented by a four-point scale. For each variable there is one intensity *1* item which reflects "a mild or necessary amount of the trait." Three items refer to intensity *2*, "a moderate or appropriate amount of the trait." Three words reflect intensity *3*, "a marked or inappropriate amount of the trait." And one word expresses intensity *4*, an "extreme amount of the trait." The Form IV check list arranged by variable and intensity is presented in Table 40. The checklist items are arranged in circular form in Figure 6, page 135.

In actual use, the check list is given in approximate alphabetical order and the subject indicates on an IBM answer sheet the items which are descriptive of himself or of the person he is rating. The check list has also been administered by means of IBM cards. Each item was printed on a separate card and the subject was requested to sort the cards into "true" and "false" piles. These cards were then machine-punched and provide a card file for IBM research studies. The methodology for IBM administration and analysis of the check list is described by LaForge in a separate paper (2).

[1] This chapter is a summary of a paper written by Rolfe LaForge, Ph.D., and Robert Suczek, Ph.D., the designers of the Interpersonal Adjective Check List. Gratitude is expressed to Drs. LaForge and Suczek for permitting the extended quotation from their manuscript. Table and footnote numbers of the original paper have been altered to conform to the series of such numbers in the present volume.

TABLE 40

Interpersonal Check List, Form 4, Words Arranged by Octant and Intensity

Octant 1: AP

A: 1 Able to give orders
- 2 Forceful
  Good leader
  Likes responsibility
- 3 Bossy
  Dominating
  Manages others
- 4 Dictatorial

P: 1 Well thought of
- 2 Makes a good impression
  Often admired
  Respected by others
- 3 Always giving advice
  Acts important
  Tries to be too successful
- 4 Expects everyone to admire him

Octant 2: BC

B: 1 Self-respecting
- 2 Independent
  Self-confident
  Self-reliant and assertive
- 3 Boastful
  Proud and self-satisfied
  Somewhat snobbish
- 4 Egotistical and conceited

C: 1 Able to take care of self
- 2 Can be indifferent to others
  Businesslike
  Likes to compete with others
- 3 Thinks only of himself
  Shrewd and calculating
  Selfish
- 4 Cold and unfeeling

Octant 3: DE

D: 1 Can be strict if necessary
- 2 Firm but just
  Hardboiled when necessary
  Stern but fair
- 3 Impatient with others' mistakes
  Self-seeking
  Sarcastic
- 4 Cruel and unkind

E: 1 Can be frank and honest
- 2 Critical of others
  Irritable
  Straightforward and direct
- 3 Outspoken
  Often unfriendly
  Frequently angry
- 4 Hard-hearted

Octant 4: FG

F: 1 Can complain if necessary
- 2 Often gloomy
  Resents being bossed
  Skeptical
- 3 Bitter
  Complaining
  Resentful
- 4 Rebels against everything

G: 1 Able to doubt others
- 2 Frequently disappointed
  Hard to impress
  Touchy and easily hurt
- 3 Jealous
  Slow to forgive a wrong
  Stubborn
- 4 Distrusts everybody

Octant 5: HI

H: 1 Able to criticize self
- 2 Apologetic
  Easily embarrassed
  Lacks self-confidence
- 3 Self-punishing
  Shy
  Timid
- 4 Always ashamed of self

I: 1 Can be obedient
- 2 Usually gives in
  Easily led
  Modest
- 3 Passive and unaggressive
  Meek
  Obeys too willingly
- 4 Spineless

Octant 6: JK

J: 1 Grateful
2 Admires and imitates others
Often helped by others
Very respectful to authority
3 Dependent
Wants to be led
Hardly ever talks back
4 Clinging vine

K: 1 Appreciative
2 Very anxious to be approved of
Accepts advice readily
Trusting and eager to please
3 Lets others make decisions
Easily fooled
Likes to be taken care of
4 Will believe anyone

Octant 7: LM

L: 1 Cooperative
2 Eager to get along with others
Always pleasant and agreeable
Wants everyone to like him
3 Too easily influenced by friends
Will confide in anyone
Wants everyone's love
4 Agrees with everyone

M: 1 Friendly
2 Affectionate and understanding
Sociable and neighborly
Warm
3 Fond of everyone
Likes everybody
Friendly all the time
4 Loves everyone

Octant 8: NO

N: 1 Considerate
2 Encouraging others
Kind and reassuring
Tender and soft-hearted
3 Forgives anything
Oversympathetic
Too lenient with others
4 Tries to comfort everyone

O: 1 Helpful
2 Big-hearted and unselfish
Enjoys taking care of others
Gives freely of self
3 Generous to a fault
Overprotective of others
Too willing to give to others
4 Spoils people with kindness

Derivation of the Interpersonal Adjective Check List

An attempt was made to develop a stimulus situation which would be a balanced representation, at various intensities, of each of the sixteen hypothesized varieties of interpersonal behavior. In assigning scores to the test responses, the "unit" assumed to be invariant became, not the standard deviation computed for a certain sample under certain scaling assumptions, but an event from a defined set of events; the subject's selection or rejection of any word in the list. The advantage of such an approach is that direct numerical comparison of raw scores (number of words in a given category checked by a subject) is possible and meaningful as a set of communications from the patient, so that a model for statistical inference need involve no untestable scaling assumptions. As a result, idiographic procedures, similar to Stephenson's Q-technique, became applicable. The disadvantage is that the selection of each item becomes of crucial importance.

Because the interpersonal system is at present typically more a method than a set of entities or measurements, any process of criterion item selection seemed likely to be premature and limiting. Instead, *a priori* selection of words by a conference of from four to six psychologists was followed

by *a posteriori* analysis of the way in which these words were actually used by the patients. Both the intuitive judgments and the empirical check were essential aspects of the developmental process.

Development and Revision of the Interpersonal Check List

General Background. The development of the Interpersonal Check List has taken place over a period of four years. Four major forms have been developed successively, the third having been twice revised.

The initial source of items was a 334 adjective check list prepared by Suczek to be representative of trait lists extant in psychological literature up to 1950. Form I was a selection of 106 interpersonal words made from this list on the basis of the pooled judgments of five psychologists. . . . The goals of the first revision were to obtain a fuller and more even representation of the varieties of interpersonal behavior. Balance among the sixteen categories in the frequency of "yes" responses obtained has been improved with each successive form, but in later revisions attention was concentrated on the meaning of the text items for each patient. . . .

Samples Tested. During the three year period of revision, the check list has been administered to several thousand subjects in a variety of ways. The principal use has been as part of the evaluation procedure for incoming patients to the psychiatric clinic. Other samples include several hundred students at the University of California, Berkeley; 100 students at San Francisco State College, San Francisco; a group of dermatitis patients from the practice of Dr. Herbert Lawrence, in San Francisco; and a group of 200 overweight women. The most frequent administration has called for a description of self. The majority of subjects have also been asked to describe their mother, father, spouse, and (for Forms IIb and IV) their ideal self. In addition, some subjects have been asked to use the list to describe people in general, to describe the characters in their TAT stories, and to describe the other members of their therapy group, i.e., as a form of sociometric. The statistical data used for revision of the check list have been derived from these samples.

Problems and Methods of Revision. Once the decision to discard standard scores and other scaling devices had been made, it was necessary to manipulate item content in order to develop comparability among variables. One difficulty was the variation in the frequency of "yes" responses among the sixteen categories. After a study of both the frequencies with which individual words on Form I were checked and the average raw scores obtained in the various sixteenth and octant categories, it was decided that the introduction of an explicit "intensity" dimension would simplify the attainment of approximately comparable raw scores. For Form II, words were rated either *2* or *3* on a four-point scale from *1* "A mild or necessary amount of a trait" to *4*, "An extreme or highly inappropriate amount." Three words in each interpersonal category were of intensity *2*, "Moderate or appropriate," while three were of intensity *3*, "Marked or inappropriate." In Forms III and IV, words or phrases fitting all four degrees of intensity were used.

A second and related task was to minimize the effect of certain extraneous determinants of the test scores. Among these are the misunderstanding or failure to recognize the meaning of a word, the selection of an alternate meaning differing from our usage, the general tendency to mark more or fewer words, and the tendency to check more or fewer "good" (positive valued) words. The latter tendency could be considered an error if it reflected a misapprehension of the testing situation rather than a habit of looking at oneself and others with such a bias. We considered all these effects to be special cases of the larger problem of differences in set, which unquestionably affect test performance, producing superficially derived effects often attributed directly to underlying personality structures. Our thought was that interviews following the test sessions would be the most fruitful method of evaluating the effect of differing sets on performance in the clinic setting, and such interviews were begun with the construction of Form III.

However, even without such interviews, it was clear from the evidence at hand that certain general shifts with respect to intensity and value were necessary. For one thing, although tallies of the octant scores showed marked differences depending on application, intensity and sample, . . . it was clear that all subjects were checking more words on the right-hand (friendly) side of the circle than on the left (hostile). To some extent this was a valid representation reflecting the inhibition of hostile expression in our culture, but largely it seemed to reflect a difference in set between patients who were using the words to describe themselves and psychologists who were judging the words from a vantage of psychopathological theory.

To correct this bias, words were rated with respect to their value in the patient culture.[1] Then new intensity ratings were given the words with an eye to their rated value and to the frequency with which they had been checked by the patients. For example, *appreciative* and *cooperative* had been checked by nearly everyone, and so were scaled down in intensity from *2* to *1*. Opposite adjustments were necessary on the left side of the circle. The empirical relation between the intensity assigned to an item and the frequency of patients' "yes" responses to the item was used in later forms to correct mis-scored items. Considerable scatter within an intensity occurred, but the rough rule was set up that intensity 1 words should be answered "yes" by about 90% of the population, intensity 2 by about 67%, intensity 3 by about 33%, and intensity 4 by about 10%. Boundaries were set between these points, and items deviating too greatly were eliminated or moved to a more appropriate intensity.

Many words, like *discriminating, conciliatory*, although agreed upon by raters and patients, had to be discarded because they were unintelligible to a sizable proportion of patients. Others, like *demanding*, were susceptible of differences in interpretation which made ambiguous their inter-

[1] Ratings of value were done on a three-point scale according as the typical patient would consider the word in question as describing a "good," "neutral," or "bad" trait.

personal score. Our evidence in these cases was the tallies of words which patients had complained about or marked as ones not understood and the intercorrelations of a word with the other words in the list. Some words were simply annoying to patients for other reasons and were discarded. An example is *pollyanna.* To develop adequate item clarity and precision, brief phrases were introduced if no single adjective could be found, although items were kept as brief as possible in the interests of speed and ease of test-taking.

In the revision of Form IIIb, the pattern of intercorrelations of each *item* with all other *items* of the same frequency was the most important source of information.[2] A good item was characterized by high correlations with neighboring items and low correlations with items more distant on the circle of variables. It is customary in validating items to use the score on a set of items as a criterion. We were able to go directly to the item-intercorrelations themselves because we were comparing items of the same relative frequency and because the whole pattern of intercorrelations had meaning. Since a poor item was associated not only with a poor pattern on its own graph, but also with a misplaced point on the graphs of other items, the effect of poor items could be discounted in our considerations as soon as one had been identified. Such adjustment is not possible if a score is used as an item criterion. In some cases, the majority of items in a category were found to be poor. For these cases, the criterion itself would have selected poor items. Approximately 6,000 item intercorrelations were examined in the revision of Form IIIb, and replacements were made for items having poor patterns.

Our fairly standard procedure at each revision was to collect statistical data on the previous form: the frequencies with which the individual words in each octant, 16th and intensity were being checked by the various samples in the several situations, the average test scores for each sample, the tally of words which the patients had marked as ones not understood, together with a summary of their verbal complaints, the octant intercorrelations, and, for Form IIIb, the item intercorrelations. To these data were added the five psychologists' ratings of each word with respect to interpersonal category and intensity. Psychologists' opinions as to the understandability and over-all desirability of each word were also recorded. Each word was then considered by a conference of from four to six psychologists. Changes in the list were of several types: the discarding of a word or phrase, assignment of a new intensity of 16th designation, or a modification in wording. The remaining list of satisfactory or modified words was used as a core for the new form of the check list. To this were added new words or phrases as required. Thesauri, as well as the

[2] It was possible to examine such a quantity of data because the test responses were already punched into IBM cards. Actually, an approximation to the intercorrelations was used, namely $\frac{\sum_i X_{ij} Y_{ik}}{\sum_i Y_{ik}}$ for a given j.

For roughly constant marginal frequencies, this approximation is good.

individual and collective inspiration of the staff, were used as sources of words which would be meaningful to all patients in the exact sense desired.

Experimental forms were now drawn up and administered to patients for two or three weeks of normal clinic intake. During this time, interviews about the test items were conducted. Patients who had just taken the test were asked to point out words which seemed unclear, ambiguous, or in any way bothersome. They were also asked to define specific words about which we had some uncertainties. Finally, a general evaluation of and reaction to the test was requested. On the basis of the data gathered with the experimental form a revision was given definitive form.

As is suggested by the above, the process of development of the ICL is a continuing one, but it was felt that sufficient progress has been made to justify publication of the present Form IV.

Results

Internal Consistency. Test-retest reliability correlations are available on 77 of the obesity sample who were retested after an interval of

TABLE 41

Test-Retest Correlations, Form IIIa, by Octant and Sixteenth (Obesity Sample, N = 77)

Octants

AP	*BC*	*DE*	*FG*	*HI*	*JK*	*LM*	*NO*
.76	.76	.81	.73	.78	.83	.75	.80

Average = .78

Sixteenths

A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*
.75	.68	.74	.83	.76	.64	.77	.65	.76	.73	.76	.66	.73	.75	.74	.69

Average = .73

two weeks. Because this sample is a somewhat homogeneous all-female group, these correlations are not likely to be larger than ones obtainable with other groups. On the other hand, obese women may have more stable self pictures than many individuals. The sort of unreliability which results from changes in one's view of self is not of course undesirable in a test designed to depict view of self. Therefore the correlations in Table 41, which average .73 for 16th reliability and .78 for octant reliability, may be thought of as suggesting that ICL scores can have sufficient stability to be useful in personality research and clinical evaluation.

Perhaps more important than reliabilities are the intervariable correlations. As in most theories, certain relationships among variables are postulated, but in the Interpersonal System these relationships are particularly accessible to the psychometrician. For example, adjacent variables on the circular continuum are more closely related than non-adjacent, and the relationship between two variables is a monotonic decreasing function of

their separation. Empirical measures of relationship, such as the correlation coefficient, offer an opportunity to check how well the postulated order holds. Interoctant and intersixteenth correlations have been obtained on several samples, and these correlations are summarized in Table 42. In Table 42, the averages of the correlations for variables one step apart, two steps apart, etc., are shown. It is evident that these averages decrease as more distant variables are correlated. Thus observations made with the check list confirm that a roughly circular arrangement of the variables can be used to describe their degree of relationship to one another.

TABLE 42

AVERAGE INTERVARIABLE CORRELATION AS A FUNCTION OF THEIR SEPARATION AROUND THE CIRCLE

DATA RECORDED IN SIXTEENTHS (RAW SCORES)

			Intervariable Distance							
Sample	*Form*	*N*	1	2	3	4	5	6	7	8
Obesity females	III	77	.46	.37	.34	.28	.24	.21	.19	.12
Psychiatric outpatient males	IIIa	76	.56	.48	.36	.26	.13	.11	.06	.06
Psychiatric outpatient females	IIIa	122	.51	.39	.25	.13	.03	−.06	−.14	−.19

DATA RECORDED IN OCTANTS

				Intervariable Distance			
Sample	*Form*	*Type of Score*	*N*	1	2	3	4
Obesity females	III	Raw Scores	77	.51	.37	.22	.12
Psychiatric outpatient males and females	II	Raw Scores	83	.60	.35	.24	.11
Psychiatric outpatient males and females	II	Divided by number of words checked	83	.28	−.08	−.44	−.48

One might ask why no appreciable negative correlations are reported among raw scores, even though variables opposite in meaning are correlated. The answer is to be found in the fact that all variables are contaminated by a common factor, the over-all likelihood of a "yes" response, regardless of item content. When this factor is removed by dividing each raw score by the total number of "yes" responses made by a subject, negative correlations do in fact appear whenever variables with opposite components of meaning are correlated. (Compare the last two lines of Table 42.) There does not seem to be any particular advantage to the division of scores by number of words used if the effect of this over-all "yes" tendency is kept in mind. For example, the correlations of raw or divided scores with MMPI variables have the same *average* absolute value, although in individual situations one or the other type of score may yield a higher correlation.

TENTATIVE CLINIC NORMS. No adequate normative data on a variety of samples are yet available. The means and standard deviations presented in Table 43 can be used as approximate norms for clinical samples. They represent the performance of all patients tested during six months' routine intake at the Permanente Psychiatric Clinic. (1, pp. 98–107)

TABLE 43

ICL MEANS AND STANDARD DEVIATIONS FOR PSYCHIATRIC OUTPATIENTS

Octant	Form IIIb (144 items)				Form IV (128 items)			
	Means		Standard Deviations		Means		Standard Deviations	
	Males N = 75	Females N = 137	Males N = 75	Females N = 137	Males N = 86	Females N = 152	Males N = 86	Females N = 152
AP	8.5	7.7	2.6	3.4	6.2	6.2	3.0	3.1
BC	8.3	6.9	2.5	2.9	6.3	5.7	2.8	2.5
DE	8.6	7.6	2.9	3.4	7.4	7.1	3.2	2.9
FG	8.7	9.4	3.6	3.7	7.3	7.7	3.2	3.4
HI	9.6	9.6	3.1	3.5	7.0	7.8	3.3	3.3
JK	9.2	8.8	2.7	2.3	7.2	8.1	2.6	3.0
LM	11.0	10.6	3.2	3.1	7.1	8.2	3.0	3.1
NO	9.3	9.4	4.3	3.4	6.4	7.7	3.0	3.8
				Vector Sum				
DOM	−1.3	−3.2	7.0	8.5	−2.0	−3.4	7.9	7.8
LOV	3.5	4.4	9.0	9.1	−0.4	2.8	8.5	8.9

References

1. LAFORGE, R., and R. SUCZEK. The interpersonal dimension of personality: III. An interpersonal check list. *J. Pers.*, 1955, *24*, No. 1, 94–112.
2. LAFORGE, R. *Notes on the application of I. B. M. techniques to the analysis of psychological data.* Unpublished paper at Oakland, Calif.: Kaiser Foundation Psychology Research, 1954.

3

The Administration, Scoring, and Validation of the Level III-TAT

The instrument employed routinely by the Kaiser Foundation clinical and research studies for measuring Level III behavior is the Thematic Apperception Test (2). This appendix presents some pertinent technical and research information relating to the Level III-TAT. The details of administration will be presented. The scoring of the TAT protocols in terms of the sixteen-variable system will then be discussed. A guide for assigning interpersonal ratings to the stories most commonly elicited is included. The basic research study which demonstrates the ability of Level III-TAT to predict future changes in overt behavior will then be reviewed.

Ten TAT stimulus cards are routinely employed. These cards were selected on the basis of their interpersonal connotations. Cards used for males and females are:

Males	*Females*
1	1
2	2
3BM	3GF
4	4
6BM	6BM
6GF	6GF
7BM	7GF
12M	12M
13MF	13MF
18BM	18GF

Administration

The TAT is administered in a group testing situation. The patients are given ten TAT cards (face down) and several sheets of blank

paper. They are instructed to make up a story about the people in the TAT stimulus picture. They are told that there should be interaction among the people in their stories. They are to state what the situation is, how the figures feel about each other, and how the situation is resolved.

While the subjects are writing their stories, the tester checks their responses to the first cards to make sure that the instructions are being followed. The average psychiatric clinic patient (mean years of schooling for women = 12.4, men = 13.2) completes the ten card TAT in forty-five minutes.

Scoring of Interpersonal Themes from TAT Stories

The TAT protocols are then rated by three independent judges who assign one or more interpersonal themes to the hero of each story and to the "other" personages.

The first step in the scoring process is the determination of the hero figure. The TAT personage who is the central figure in the story is designated the hero. There are criteria used to make this decision.

(1) The figure with whom the subject is most involved is the hero.
(2) The figure receiving the most descriptive space is the hero.
(3) The figure who parallels the subject's age and sex is the hero.

These criteria are listed in descending order of importance. In most cases it is not necessary to apply these criteria—the hero is obvious. Only where the issue of centrality is in doubt are these three criteria applied. In some cases both characters or all characters mentioned can be considered the hero if no distinction or separation between figures is made by the patient.

The second step in scoring a TAT story is to assign the appropriate interpersonal ratings to the hero. If the "other" figures are attributed interpersonal feelings or actions these are then scored. Two raters and a judge are used to score the TAT protocols which are being used for research purposes. For routine clinical diagnosis it is often necessary to rely on single ratings.

There are two methods for rating TAT themes. The first employs the sixteen-variable lettered code (B = narcissism, C = exploitation, etc.). The second employs the numerical octant codes (2 = narcissism-B or exploitation-C, etc.). Since the octant scores are employed in the trigonometric summary formulas, the numerical system is now routinely used by the Kaiser Foundation system.

A strict legislative procedure has been developed for the judging process. The first two raters make their scoring decisions independ-

ently. The judge then inspects these ratings and makes a third and decisive rating only in the case where the first two independent raters are in disagreement. The judge cannot change a rating if the first two raters agree on the same octant score. If the first two raters disagree on the octant score the judge then has the authority to agree with either of the raters or to substitute a third rating. The judge's ruling is final.

In some cases the first two raters assign more than one score to any TAT figure. They may agree on one score but disagree on the second score. A rule has been developed to handle this eventuality. If there is any disagreement in scores assigned to a TAT figure, the judge has the right to change all the scores assigned to that figure.

A manual has been prepared to assist in the training of TAT raters. Table 44 presents the most typical themes assigned to the figure in the ten-card TAT employed by the Kaiser Foundation project. Percentage figures indicating the relative frequency of appearance of these themes are included in Table 44.[1] These percentages are sometimes reflections of the figure chosen as Hero. They are included for didactic purposes only.

TABLE 44
GUIDE TO ASSIGNING INTERPERSONAL RATINGS TO TEN TAT STORIES (LEVEL III-T)

CARD 1

Hero (Little Boy)

	Hero Letter Code	*Numerical Code*	%
(a) The boy feels rebellious and passively resists his parents wishes that he play the violin.	*F*	4	39
(b) He experiences success in later life.	*P*	1	27
(c) He is daydreaming.	*J*	6	11
[The score *J* is also assigned when the boy is conforming to his parents wishes. If he is dreaming about success, he gets the double score for passivity and achievement.]	*J* and *P*	61	
(d) He feels left out and unhappy.	*H*	5	21
(e) He has feelings of failure or impotence.	*I*	5	
(f) He asserts his will actively, often against his parents.	*B*	2	3

Other (Parents or Parent Figures)

	Other Rating	%
(a) The parents are forcing the boy to play the violin.	*A*	47
(b) They give the boy the violin or support him in his efforts.	*N* or *O*	19
(c) They are punitive or unsympathetic.	*D* or *E*	14

[1] The percentage scores contained in Table 44 were derived by John Enright of the University of California and Joan S. Harvey of the Kaiser Foundation staff.

CARD 2

Hero (Girl with Books)

		Hero Rating	%
(a)	The girl feels or acts independently.	*B*	28
(b)	She feels rebellious, resentful, or deprived.	*F* or *G*	21
(c)	She conforms and gives up her independent strivings.	*J*	11
(d)	She adjusts herself agreeably, and a happy ending results.	*L*	7
(e)	She gives things to or supports her parents.	*O*	13
(f)	She asserts independence but regrets decision in later life.	*B* and *H*	

Other (Usually Family Members)

		Other Rating	%
(a)	The family members are selfish or rejecting [most common score for neurotic groups].	*B* or *C*	29
(b)	They are generous and sympathetic.	*N* or *O*	19
(c)	They are angry because the girl is rebellious.	*D*	13
(d)	They are docile, conforming people.	*J*	4

Comments: If the family members are mentioned in a descriptive sense they are not scored (e.g., man plowing, woman is pregnant). If their activities put interpersonal pressure on the girl they are given the appropriate score (e.g., the man's conformity contrasted to the heroine's desire for independence, etc.).

BM
CARD 3 GF

Hero (Solitary Figure)

[Since there are no differences in the percentages of scores assigned to Cards 3 GF and 3 BM, they are considered together.]

		Hero Rating	%
(a)	The Hero is depressed, defeated, suicidal, etc.	*H*	46
(b)	The Hero is bitter, disappointed, exploited.	*F* or *G*	23
(c)	The Hero resolves the problem through conformity or trust.	*J* or *K*	4
(d)	A happy ending.	*L*	3

[The last two scores involve generally subsidiary or outcome themes.]

Others

		Other Rating	%
(a)	The world is rejecting.	*C*	31
(b)	The world is punitive or sadistic.	*D* or *E*	38
(c)	The world is sympathetic and helpful.	*N* or *O*	23

CARD 4

Hero (Man or Woman*)

		Rating
(a)	The man is striving for independence or rejecting the woman.	*B* or *C*
(b)	Feelings of despair, indecisiveness, guilt, and immobility.	*H*(1)
(c)	The woman dependently pleads with the man.	*J* or *K*
(d)	The man has angry or punitive feelings.	*D* or *E*
(e)	The man is involved in rebellious or criminal activities.	*F* or *G*
(f)	The woman forcibly (or in a wise manner) pleads with the man not to engage in impulsive or rash activity.	*A* or *P*

* *Comment:* The "Hero-Other" distinction varies according to sex. We have therefore designated the most common themes without "Hero" and "Other." For this reason no per cent figures can be cited.

CARD 6 BM

Hero (Man)

		Hero Rating	%
(a)	The man (son) strives for independence (e.g., towards marriage, career, etc.).	*B*	35
(b)	The man feels guilt and unhappiness (often accompanying the separation from the mother).	*H*	27
(c)	The man is bitter, rebellious, engaged in crime, etc.	*F* or *G*	11

Other (Woman)

		Other Rating	%
(a)	The mother is unhappy because of the son's departure or wrongdoing (or because of bad news).	*H*	26
(b)	The mother attempts directly or indirectly to prevent the son from leaving her.	*C*	18
(c)	The mother is hurt or bitter.	*F* or *G*	17
(d)	The mother gives blessing.	*N*	
(e)	The mother eventually accepts situation.	*J*	
(f)	She learns to love daughter-in-law, and all are happy.	*L*	

[(e) and (f) scores assigned to outcome themes.]

CARD 6 GF

[The Hero on this card generally varies according to the sex of the subject. The most typical responses for females will therefore be listed separately from the males.]

Females

		Hero Rating	%
(a)	The woman is fearfully surprised by the man.	*H*	17
(b)	She is rejecting or refusing the man.	*B* or *C*	23
(c)	She is pleasantly surprised by the man's offer.	*J* or *K*	10
(d)	She has committed a rebellious or deceitful act. Feels bitter or dissatisfied.	*F* or *G*	14

Males

(a)	The man is surprising the woman for exploitive or seductive purposes.	*C*	28
(b)	He is surprising the woman with an offer of tenderness or generosity or love.	*N* or *O* *M*	28
(c)	He is accusing her of crimes of omission or commission.	*D*	15

CARD 7 GF

Hero (Daughter)

		Hero Rating	%
(a)	The girl is docilely listening to the older woman (or depending on her).	*J* or *K*	28
(b)	She feels rebellious, bitter, hurt, or passively resistant.	*F* or *G*	16
(c)	She is unhappy or fearful.	*H* or *I*	22
(d)	She grows up and attains success and motherhood.	*P*	12

Other (Older Woman)

	Other Rating	%
(a) She is reading to or advising the girl.	*P*	37
(b) She is comforting or helping the girl.	*O*	33

CARD 7 BM

Hero (Young Man)

	Hero Rating	%
(a) Young man is listening to or asking advice from the older man.	*J* or *K*	30
(b) He is bitter or rebelling against unsought-for advice.	*F*	11
(c) He feels helpless or guilty.	*H* or *I*	30
(d) He is actively resisting, establishing independence, or is involved in an exploitative maneuver.	*B* or *C*	19

Other (Older Man)

	Other Rating	%
(a) He is advising the young man.	*A* or *P*	48
(b) Themes of arrogance or exploitation are attributed to the older man.	*B* or *C*	19
(c) He is helping or supporting the young man.	*O*	10

CARD 12 M

Hero (Boy)

	Hero Rating	%
(a) The boy is sick, unconscious, hypnotized, or asleep.	*I*	36
(b) He docilely or dependently pulls help from the other.	*J* or *K*	12

Other (Man)

	Other Rating	%
(a) The man is hypnotizing or exerting power.	*A* or *P*	20
(b) He is helping, curing, praying over, or tenderly ministering.	*N* or *O*	29
(c) He is selfishly exploiting the other.	*B* or *C*	15

CARD 13 MF

Hero (Man)

	Hero Rating	%
(a) The man is unhappy, despairing, guilty, immobilized.	*H* or *I*	37
(b) An unconventional or immoral act has occurred.	*F*	15
(c) A murderous or sadistic act.	*D* or *E*	10
(d) An exploitive or selfish action (e.g., rape, seduction, taking by force from the other).	*B* or *C*	16

Other (Woman)

	Other Rating	%
(a) The woman is sick or exhausted.	*I*	36
(b) She is unconcerned or satisfied (usually in contrast to the man's sexual guilt).	*B* or *C*	17

CARD 18 BM

Hero (Man)

		Hero Rating	%
(a)	The man is unconscious, drunk, passive, defenseless, etc.	*H* or *I*	57
(b)	He has committed a criminal or rebellious act.	*F*	6
(c)	He is struggling with outside forces.	*B*	20
(d)	He is dependent upon others.	*J* or *K*	9

Other (Hands)

		Other Rating	%
(a)	Others are punishing, attacking, or arresting the Hero.	*D* or *E*	32
(b)	Others are exploiting or manipulating the Hero for their own purposes.	*B* or *C*	29
(c)	Others are helping, protecting, or rescuing the Hero.	*N* or *O*	25
(d)	Others are restraining or exerting power over the Hero (where the power is neither clearly hostile nor helpful).	*A* or *P*	11

CARD 18 GF

[Both figures in this card can play the Hero role. The typical themes attributed to each figure are as follows:]

Top Figure

		Rating
(a)	The woman is unhappy because of the illness (or injury) of the other.	*H*
(b)	The woman is angry or punitive toward the other.	*D* or *E*
(c)	She is helping the injured or ill other.	*O*
(d)	She is suspicious or bitter about the other's behavior.	*F* or *G*

Lower Figure

		Rating
(a)	The lower figure is injured or ill.	*I*
(b)	She is hostile to or fighting with the other.	*D* or *E*
(c)	She has done something rebellious, "wrong," or sneaky.	*F*

MANAGEMENT OF TAT SCORES. The TAT ratings are entered by the three raters on a scoring form. This form (see Table 45) contains boxes for the two raters and the judge to record their decisions and additional space for performing the calculations necessary to convert the scores into summary indices.

After the rating and judging, the judge's scores (columns on the right of Table 45) are then tallied by octant (bottom right of Table 45). The octant scores are then fed into the trigonometric formulas (see Chapter 6), and the horizontal and vertical indices for both "hero" and "other" are calculated.

Subtotals for the themes attributed to males, females, and maternal and paternal figures can also be entered in the appropriate boxes of the scoring sheet. The 10-card TAT does not yield enough scores to diagnose these fantasy figures reliably.

TABLE 45

Molar Rating Sheet

Subject _____ Group No. _____ TAT No. _____ Date _____

Rater _____ Rater _____ Rater _____

#	Hero	Hero Role	Other	Other Role	Hero	Hero Role	Other	Other Role	Hero	Hero Role	Other	Other Role
1												
2												
3 B M G F												
4												
6 B M												
6 G F												
7 B M G F												
12 M												
13 MF												
18 B M G F												

	Maternal Id.		Paternal Id.		Parental Id.		Cross-Sex			Hero	Other	Total
	Hero	Mother	Hero	Father	Hero	Parents	Hero	Other				
									AP			
									BC			
									DE			
									FG			
									HI			
									JK			
									LM			
									NO			
									Total			
Dom									Dom			
Lov									Lov			

The horizontal and vertical indices for "hero" and for "other" are then converted into standard scores and plotted on the diagnostic grid to determine the Level III-T diagnostic categories.

Norms for the TAT. The vertical and horizontal indices for Level III-T are converted into standard scores derived from a sample of 100 consecutive patients tested at the Permanente Psychiatric clinic. The means and sigmas of the normative group are presented in Table 46.

TABLE 46

Means and Sigmas of Normative Group for Level III-T Hero and "Other" (N = 100)

	Hero			*Other*	
	$\bar{X}$	σ		$\bar{X}$	σ
DOM	−5.67	3.37	DOM	−0.04	2.41
LOV	+0.09	2.98	LOV	−0.26	2.59

The Basic Validation Study Demonstrating That Level III-TAT (Hero) Predicts Changes in Future Overt Behavior

In Chapter 8 (and in the subsequent clinical chapters) it was suggested that fantasy expressions predict personality changes which can be expected in the future. A research study designed to test this hypothesis has been executed and will now be reported. The subjects in these investigations were given tests of conscious self-description and the TAT before psychotherapy (or a control period). Six months later the test of conscious self-description was repeated. The issue is this: did the TAT's given before the experimental period forecast the amount and kind of change which took place over time?

Subjects. Two samples of subjects were employed in this research. The first comprised 42 psychiatric clinic patients who were tested before and after six months of psychotherapy.

There were no apparent extraneous selective factors which might artificially influence the results.

A second control sample was also studied: 81 are female subjects who were participating in a weight-reduction program [2] and were tested before and after a six-month period in which they attended discussion groups on dietary problems. These groups did not have a psychotherapeutic orientation. Although less change in personality occurred in these groups, it was believed that an important test of the predictive hypothesis would be furnished if it could be demonstrated that the TAT's (before the experimental period) would predict whatever changes in personality did take place in these subjects.

[2] Volunteers for a group weight-reduction study at Herrick Memorial Hospital, Berkeley, California.

METHOD OF PROCEDURE. All subjects in the study were initially administered two tests—the TAT and the Interpersonal Check List on which they rated their conscious perceptions of self. The construction and validation of this check list has been described in Appendix 2. The check list scores were converted into the sixteen (eight moderate, eight intense) summary interpersonal diagnostic categories.

Every subject in this study thus received a two-level interpersonal diagnosis—one for his conscious self-description derived from the check list and one for his private, "preconscious" behavior derived from the TAT. A subject, for example, on the basis of his initial testing might receive the following diagnoses: Level II = 5; Level III = 1. This indicates that his self-descriptions were masochistic and self-effacing while his TAT heroes were autocratic and power-oriented.

The method presented in Chapter 13 for expressing in numerical indices interlevel differences was employed. These indices denote the kind and amount of discrepancy between the two levels of personality being compared. The discrepancy index for the illustrative subject just considered is: Dominance-Submission = +112; Love-Hate = +22; d = 114 (see Table 58, Appendix 5). These figures indicate that the subject's TAT hero is considerably more dominating (+112) and slightly less hostile (+22) than his conscious self-description. The over-all discrepancy between the two levels is the highest possible (114). This means that his TAT expresses themes which are most different from his conscious self-perceptions.

Each subject in the study was administered the Interpersonal Check List after approximately six months. A diagnostic code was then derived for each post-test. The illustrative case was self-diagnosed (after six months of therapy) as a narcissistic personality, code = 2. The preresearch score for each subject at Level II was then compared with the post-Level II score by means of the same "discrepancy" methodology. This yields a numerical index of change at the level of conscious self-description. For the illustrative case the Level II diagnosis changed from 5 to 2. The indices for this change are: Dominance-Submission = +103; Love-Hate = −21; d = 105. These figures mean that the subject became (in his self-regard) much stronger and more dominant (+103) and slightly more hostile (−21). His over-all amount of change was considerable (105 in a possible range of 0 to 114).

For each patient in the psychotherapy sample and for each subject in the control sample the two sets of discrepancy indices were obtained: the preresearch discrepancy between the Interpersonal Check List and the TAT and the discrepancy between the pre- and post-check lists.

Two hypotheses were then stated: the discrepancies between the conscious self-description and the TAT from the initial testing would predict (1) the *kind* of pre-post change in self-description and (2) the *amount* of pre-post change at this level. In the illustrative case the TAT did predict quite closely the increased dominance in the post- check list (+112 versus +103); the TAT did not predict the shift on the Love-Hate axis (+22 versus −21). The discrepancy between the initial check list and TAT did predict quite accurately the amount of over-all change in Level II over time (114 versus 105).

Results. There are two sets of results: those which reflect the ability of the TAT to predict the *kind* of change to be expected over time and those which test the TAT's accuracy in predicting the *amount* of change. In the former study two measures are involved, the Dominance-Submission discrepancy and the Love-Hostility. If the TAT expressed more dominance than the initial self-description a plus (+) score is obtained. If the pre-post discrepancy in the self-description yielded a plus score on dominance, then the TAT was considered to have predicted accurately the kind of change. The same type of plus and minus (−) measures for the Love-Hostility axis were similarly compared.

The results for the psychotherapy and control samples are presented in Tables 47, 48, 49, 50, 51, and 52. For the psychotherapy sample the TAT does not predict change in Level II Dominance-Submission (Table 47), but it does forecast change in hostility attributed

TABLE 47

Chi-Square Relating the Kind of Initial Discrepancy on Dominance-Submission Between Conscious Self-Diagnosis and TAT Diagnosis to the Kind of Change in Self-Diagnosis of Dominance-Submission on Pre-Post Tests for 23 Psychotherapy Patients

		TAT More Dominant Than Initial Conscious Self-Description	TAT More Submissive Than Initial Conscious Self-Description
		+	−
Post Self-Diagnosis More Dominant Than Initial Self-Diagnosis	+	10	5
Post Self-Diagnosis More Submissive Than Initial Self-Diagnosis	−	6	2

X^2 is not significant.

TABLE 48

CHI-SQUARE RELATING THE KIND OF INITIAL DISCREPANCY ON DOMINANCE-SUBMISSION BETWEEN CONSCIOUS SELF-DIAGNOSIS AND TAT DIAGNOSIS TO THE KIND OF CHANGE IN SELF-DIAGNOSIS OF DOMINANCE-SUBMISSION ON PRE-POST TESTS FOR 40 DISCUSSION GROUP CONTROLS

		TAT More Dominant Than Initial Conscious Self-Description	TAT More Submissive Than Initial Conscious Self-Description
		+	-
Post Self-Diagnosis More Dominant Than Initial Self-Diagnosis	+	16	7
Post Self-Diagnosis More Submissive Than Initial Self-Diagnosis	-	5	12

$X^2 = 6\ 32$; $p = .02$.

to self (Table 50). For the control sample of obese discussion group members, the TAT does predict both the change in Dominance-Submission (Table 48, $p = .02$) and in Love-Hostility (Table 51, $p = .05$). When the therapy and control groups are combined, the TAT predicts change in Dominance (Table 49, $p = .10$) and in Love (Table 52, $p = .01$).

TABLE 49

CHI-SQUARE RELATING THE KIND OF INITIAL DISCREPANCY ON DOMINANCE-SUBMISSION BETWEEN CONSCIOUS SELF-DIAGNOSIS AND TAT DIAGNOSIS TO THE KIND OF CHANGE IN SELF-DIAGNOSIS OF DOMINANCE-SUBMISSION ON PRE-POST TESTS FOR COMBINED SAMPLES OF 23 PSYCHOTHERAPY PATIENTS AND 40 OBESITY PATIENTS

		TAT More Dominant Than Initial Conscious Self-Description	TAT More Submissive Than Initial Conscious Self-Description
		+	-
Post Self-Diagnosis More Dominant Than Initial Self-Diagnosis	+	26	12
Post Self-Diagnosis More Submissive Than Initial Self-Diagnosis	-	11	14

$X^2 = 3.71$; $p = .10$.

TABLE 50

CHI-SQUARE RELATING THE KIND OF INITIAL DISCREPANCY ON LOVE-HOSTILITY BETWEEN CONSCIOUS SELF-DIAGNOSIS AND TAT DIAGNOSIS TO THE KIND OF CHANGE IN SELF-DIAGNOSIS OF LOVE-HOSTILITY ON PRE-POST TESTS FOR 23 PSYCHOTHERAPY PATIENTS

		TAT Less Hostile Than Initial Conscious Self-Description	TAT More Hostile Than Initial Conscious Self-Description
		+	-
Post Self-Diagnosis Less Hostile Than Initial Self-Diagnosis	+	5	1
Post Self-Diagnosis More Hostile Than Initial Self-Diagnosis	-	5	12

$X^2 = 5.06$; $p = .05$.

Several comments can be made about these results. The *N*'s cited are smaller than those given for the original samples because in the "direction-of-change" study those patients who had no initial Level II versus III discrepancy or no Level II pre-post discrepancies were omitted, since plus or minus signs were not available. They are included below in the "amount-of-change" study where "no-change" becomes a most significant statistic.

TABLE 51

CHI-SQUARE RELATING THE KIND OF INITIAL DISCREPANCY ON LOVE-HOSTILITY BETWEEN CONSCIOUS SELF-DIAGNOSIS AND TAT DIAGNOSIS TO THE KIND OF CHANGE IN SELF-DIAGNOSIS OF LOVE-HOSTILITY ON PRE-POST TESTS FOR 40 DISCUSSION GROUP CONTROLS

		TAT Less Hostile Than Initial Conscious Self-Description	TAT More Hostile Than Initial Conscious Self-Description
		+	
Post Self-Diagnosis Less Hostile Than Initial Self-Diagnosis	+	11	10
Post Self-Diagnosis More Hostile Than Initial Self-Diagnosis	-	4	15

$X^2 = 4.18$; $p = .05$.

TABLE 52

CHI-SQUARE RELATING THE KIND OF INITIAL DISCREPANCY ON LOVE-HOSTILITY BETWEEN CONSCIOUS SELF-DIAGNOSIS AND TAT DIAGNOSIS TO THE KIND OF CHANGE IN SELF-DIAGNOSIS OF LOVE-HOSTILITY ON PRE-POST TESTS FOR COMBINED SAMPLES OF 23 PSYCHOTHERAPY PATIENTS AND 40 OBESITY PATIENTS

		TAT Less Hostile Than Initial Conscious Self-Description	TAT More Hostile Than Initial Conscious Self-Description
		+	-
Post Self-Diagnosis Less Hostile Than Initial Self-Diagnosis	+	16	11
Post Self-Diagnosis More Hostile Than Initial Self-Diagnosis	-	9	27

$X^2 = 7.57$; $p = .01$

The fact that the TAT works better as a predictive instrument for the control group than the psychotherapy group is somewhat puzzling. It may be explained by the fact that the psychotherapy patients were retested during a period of greater personality change (1). Our research has demonstrated that therapy patients go through more pronounced and varied cycles of change depending on the kind and duration of psychotherapy.

Another important consideration in evaluating these results is the possible existence of extraneous or artificial factors pushing the findings in a falsely positive direction. One possibility is that the change in pre-to-post testing could be the result of a regression to the mean. If the second tests yielded less intense or less extreme scores or if the initial TATs were less extreme than the initial self-descriptions, then the results would be due to a statistical artifact. An examination of the data revealed that neither of these situations existed. *At this point it seems possible to accept the hypothesis that there is a general and significant tendency for private, "preconscious" fantasy material (as tapped by the TAT) to predict the kind of future changes in conscious self-perception.*

The second hypothesis concerned the ability of the TAT to predict the *amount* of change. It will be recalled that the third discrepancy score (d) mentioned above reflects the linear distance on the diagnostic grid between the initial self-description score and the TAT, or the distance between any pre-versus-post comparison. If the second

hypothesis is correct, the greater the conflict or discrepancy within the pretest personality, the greater the change over time. Conversely, the more rigid and tightly organized the pretest personality the smaller the change to be expected. Defined operationally: a large "d" score between Level II and Level III in the pretesting predicts to a large "d" score between the pre- and posttesting at Level II.

This comparison was made for the psychotherapy sample and the discussion group controls. The hypothesis did not hold for the therapy sample. A large conflict between self-diagnosis and TAT was not related to a large pre-post therapy change. It did hold for the discussion group sample. As will be seen in Table 53, the greater the discrepancy between the self-diagnosis and the TAT in the pretesting, the more likely a large change in self-diagnosis over time. For the discussion group controls it can be said that structural (interlevel) variability predicts to temporal variability.

TABLE 53

CHI-SQUARE RELATING THE AMOUNT OF DISCREPANCY BETWEEN CONSCIOUS SELF-DIAGNOSIS AND TAT DIAGNOSIS TO AMOUNT OF TEMPORAL CHANGE IN SELF-DIAGNOSIS FOR 81 DISCUSSION GROUP CONTROLS

	Small Discrepancy (d) Between Self-Diagnosis and TAT in Initial Testing	Large Discrepancy (d) Between Self-Diagnosis and TAT in Initial Testing
Small Discrepancy (d) Between Pre and Post Self-Diagnosis	27	15
Large Discrepancy (d) Between Pre and Post Self-Diagnosis	16	23

$X^2 = 4.40$; $p = .05$.

The question as to why the hypothesis holds for one sample and not the other cannot be answered satisfactorily at this point. It may be due to the complexities and peculiarities of either sample. One answer may lie in the fact that the psychotherapy sample tends to be loaded with individuals who manifested severe interlevel conflict before therapy and relatively less change during therapy. The typical therapy patient, as described in another publication (1), is guilty, depressed, and passive in self-diagnosis and expresses underlying themes of power and narcissism. Although some change does occur in therapy patients, this intense conflict does not get resolved during the six-month period covered by the pre-post testing. Further research into

the nature and sequence of change in psychotherapy may provide the solution to this issue.

Summary

This paper has presented a theory of and measurement method for dealing with imaginative, "preconscious" behavior. Some functions of imaginative expressions were presented. These included reduction of anxiety and internal tension, maintenance of the feeling of self-esteem and uniqueness, the time-binding postponement of impulse. The implication of these theories is that imaginative productions can be used by the psychologist to determine the amount of and interpersonal sources of anxiety and to predict future behavior. The Kaiser Foundation method for rating the interpersonal aspects of imaginative expressions was described and employed for illustration purposes to a dream of Sigmund Freud. This method was then applied to two sets of data to test the hypothesis that fantasy expressions predict the amount and kind of change to be expected in future conscious self-descriptive behavior. The results tended to support the notion that the *kind* of structural (interlevel) variability between levels in pretesting predicts the *kind* of variability to occur in the future. The hypothesis that the amount of structural variability is related to the amount of temporal variability was found to hold for one sample and not the second.

References

1. Leary, T., and Joan Harvey. A methodology for measuring personality changes in psychotherapy. *J. clin. Psychol.*, 1956, *12*, No. 3, 123–32.
2. Murray, H. A. *Thematic Apperception Test.* Cambridge: Harvard University Press, 1943.

4

The Interpersonal Diagnostic Report

The multilevel pattern of scores provided by the interpersonal system is employed to make diagnostic and prognostic statements about patients who are being evaluated for psychotherapy. The scores can be converted into predictions about the interpersonal behavior to be expected in the subsequent clinical contacts.

The diagnostic report focuses on the functional aspects of the patient's personality in terms of five areas:

1. Motivation for psychotherapy
2. "Preconscious" conflicts and the associated defensive processes
3. Summary of conscious and "preconscious" identification patterns and the predicted transference possibilities
4. Analysis of the ego-structure, ego strength, potential psychotic tendencies
5. Prognosis of response to psychotherapy

In developing these clinical implications of the interpersonal profile, we have been influenced by the concepts of Merton Gill *et al.* In the book *The Initial Interview in Psychiatric Practice* (1) Gill, Newman, and Redlich outline a theory and technique for assessing the variables which are crucial to prognosis.

A sample diagnostic report will now be presented. First the multilevel personality pattern and the family relationships (as measured by the interpersonal system) are described; then the clinical implications of the profile are listed.

Multilevel diagnosis is accomplished most efficiently by using the "Record Booklet for Interpersonal Diagnosis of Personality." A copy of this printed booklet is presented in Figure 61. The raw scores, standard scores, diagnostic profiles, and calculations of variability indices for the sample case are included for illustrative purposes in this figure. The data listed in the diagnostic booklet will allow the reader to follow the step-by-step derivation of the multilevel diagnosis. The

norms for converting raw scores at Levels I-M, II-C, III-TAT (Hero), and III-TAT (Other), and the weighted scores for variability indices are listed in Appendix 5.

In this illustrative case the patient was retested after psychotherapy. The personality profile after therapy will be examined to check on the accuracy of the original predictions and to illustrate the use of the interpersonal system in measuring personality change. The posttherapy (second testing) Level I-M and II-C diagnoses of this sample patient are not presented in the pretherapy diagnostic booklet. In order to illustrate the diagrammatic measurement of *change* in personality, Figure 62 presents the pretherapy multilevel pattern and the posttherapy scores at Levels I and II.

Personality Evaluation of Case 6618

Multilevel Personality Profile. This 40-year-old man manifests extreme depression and helpless dependence in his symptoms (see Figure 61). His MMPI can be seen as a plea for help and an expression of weakness, fear, and impotence.

In his conscious self-description he presents a similar picture. He tells us he is passive, self-effacing, and timid. He denies hostility or strength.

His "preconscious" expressions (Level III-T Hero) present a different picture. Moderate strength and independence appear at this underlying level. His deeper fantasy descriptions of "others" involve agreeability and nurturance.

The pattern of these four scores (6618) defines a conflict between two levels of overt passivity and underlying feelings of power. The strength which is consciously denied appears close to the surface in his imaginative productions.

Interpersonal Diagnosis. Dependent-masochistic personality with underlying feelings of power and nurturance.

Psychiatric Diagnostic Impression. Phobic personality.

Family Dynamics. This patient sees his father as a weak, self-effacing person. His mother is assigned extraordinary power and prestige (being more than two sigmas above the mean dominance score). His wife is seen as a strong, responsible person.

A definite compartmentalization of sex roles is revealed. Females are strong and nurturant. Males are weak and docile.

His ego ideal falls very close to his pictures of wife and mother. This indicates he idealizes the female relatives and devaluates his own and his father's weakness. An insecure grasp on a masculine identification is suggested.

Record Booklet For Interpersonal Diagnosis of Personality

Subject _____ (LAST NAME FIRST NAME) Age 40 Sex M Date _____ Testing # 1

Address _____ City _____ Phone _____ Education 10

Occupation AUTO MECHANIC Marital Status MARRIED Occupation of Spouse HOUSEWIFE

Referred by _____ Therapist _____ Group _____

Other _____

Identifying Codes for Clinical and Sociological Data

Sex	MALE	1	Therapist		17		33
Age	40	2	Type of Therapy	INDIVIDUAL	18		34
Religion	JEWISH	3	Times Seen	15	19		35
Number of Siblings	3	4	Disposition	SELF	20		36

Tests covered by this record.

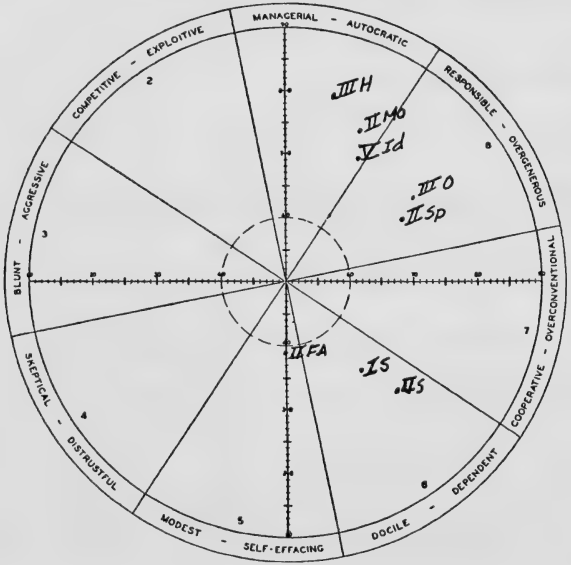
Name	Form	Testing #
MMPI		1
ICL	IV	1

Marital Status . . . . . M 5	Condition . . . . . IMPROVED 21		37	~~1ST~~ TAT	3	1
Number of Children . . . 2 6			38			
		22	39			
Subject's Occupation . . AUTOMECHANIC 7		23	40			
Occupation of Mother . . SALESWOMAN 8		24	41			
Occupation of Father . . PEDDLER 9		25		Remarks:		
Occupation of Spouse . . HW. 10			42			
		26	43			
Subject's Education . . . 10 11		27	44			
Mother's Education . . . 12 12		28	45			
Father's Education . . . 6 13			46			
Spouse's Education . . . 12 14		29	47			
		30	48			
Referred by . . . . . M.D. 15		31	49			
Previous Consultations NO 16		32	50			

This booklet was prepared by Timothy Leary, Ph.D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California. Checklists, booklets, templates, norms, and instruction manuals can be obtained from the Psychological Consultation Service.

FIGURE 61

Interpersonal Diagnosis
Multi-Level Personality Pattern

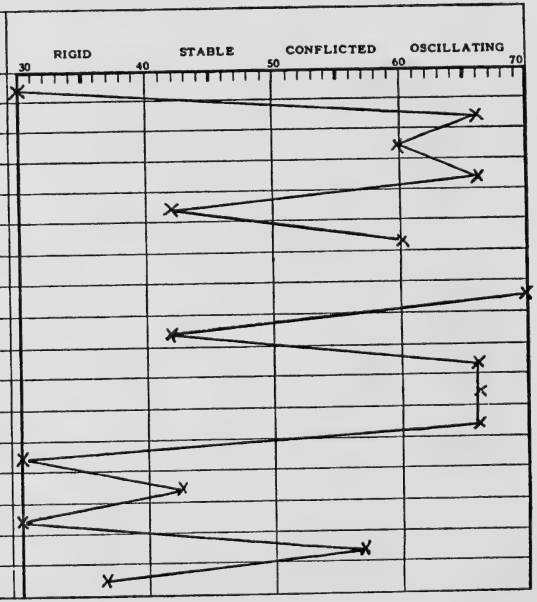


Level and Person	Test	Raw Score D	Raw Score L	Standard Score D	Standard Score L	IP Diagnosis
I S	MMPI	-56	+23	37	61	6
I S	Socio.					
I S	———					
II S	ICL	-16.4	+16.8	33	67	6
III H	~~TAT~~ TAT	+4.0	+2.6	79	58	1
V	ICL	+12.0	+11.6	69	61	1
II M	ICL	+15.1	+11.9	73	62	1
II F	ICL	-11.4	+1.4	39	50	5
II Sp	ICL	+4.5	+18.7	59	69	8
II ___	ICL					
III 0	~~IFT~~ TAT	+2.8	+5.0	62	70	8
III M	IFT TAT					
III F	IFT TAT					
III Sp	IFT TAT					

FIGURE 61 (*cont.*)

Indices of Variability Among Levels of Personality

Verbal Definition of Index	Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
SELF-DECEPTION	IS IIS	66	0	0	0	
REPRESSION Hero	IIS IIIH	61	+103	-21	105	
REPRESSION Other	IIS IIIO	68	+79	+15	81	
CONSCIOUS IDENTIFICATION Maternal	IIS IIM	61	+103	-21	105	
CONSCIOUS IDENTIFICATION Paternal	IIS IIF	65	-9	-43	44	
CONSCIOUS IDENTIFICATION Marital	IIS IISp	68	+79	+15	81	
CONSCIOUS IDENTIFICATION	IIS II_					
EQUATION Mother-Father	IIM IIF	15	-112	-22	114	
EQUATION Mother-Spouse	IIM IISp	18	-24	+36	44	
EQUATION Father-Spouse	IIF IISp	58	+88	+58	105	
CONSCIOUS SELF-ACCEPTANCE	IIS V	61	+103	-21	105	
SELF ACTUALIZATION	IS V	61	+103	-21	105	
PRECONSCIOUS SELF-ACCEPTANCE	IIIH V	11	0	0	0	
PRECONSCIOUS SELF-ACCEPTANCE	IIIO V	81	+24	-36	44	
MATERNAL IDEALIZATION	IIM V	11	0	0	0	
PATERNAL IDEALIZATION	IIF V	51	+66	+12	68	
SPOUSE IDEALIZATION	IISp V	81	+14	-22	26	



PRECONSCIOUS IDENTIFICATION—Maternal	IIS IIIM					
PRECONSCIOUS IDENTIFICATION—Paternal	IIS IIIF					
PRECONSCIOUS IDENTIFICATION—Marital	IIS IIISp					
PRECONSCIOUS IDENTIFICATION—Maternal	IIIH IIM	11	0	0	0	
PRECONSCIOUS IDENTIFICATION—Paternal	IIIH IIF	15	-112	-22	114	
PRECONSCIOUS IDENTIFICATION—Marital	IIIH IISp	18	-24	+36	44	
FUSION Maternal	IIM IIIM					
FUSION Paternal	IIF IIIF					
FUSION Spouse	IISp IIISp					
DISPLACEMENT Maternal—Paternal	IIM IIIF					
DISPLACEMENT Maternal—Cross-sex	IIM IIISp					
DISPLACEMENT Paternal—Maternal	IIF IIIM					
DISPLACEMENT Paternal—Cross-sex	IIF IIISp					
DISPLACEMENT Spouse—Maternal	IISp IIIM					
DISPLACEMENT Spouse—Paternal	IISp IIIF					

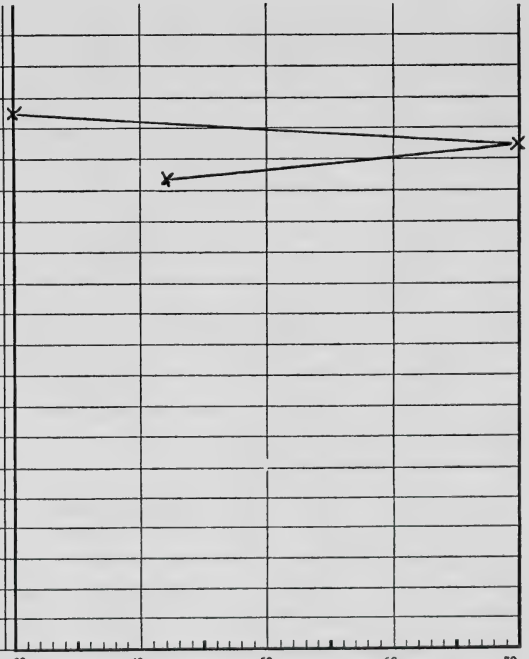


FIGURE 61 (*cont.*)

Verbal Summaries of Variability Indices

Subject misperceives his own (NO SELF-DECEPTION).

Subject is consciously identified with FATHER'S PASSIVITY.

Subject is consciously disidentified with MOTHER & WIFE'S STRENGTH.

Subject represses POWER & MANAGERIAL FEELINGS.

Subject represses (deeper) NURTURANCE.

Subject consciously equates MOTHER & WIFE.

Subject's conscious acceptance of self is VERY LOW.

Subject's self-actualization is VERY LOW.

Subject's preconscious acceptance of self is VERY HIGH.

Subject's preconscious acceptance of self (deeper) is HIGH.

Subject consciously idealizes MOTHER & WIFE.

Subject consciously devaluates FATHER.

Subject is preconsciously identified with MOTHER & WIFE.

Subject is preconsciously disidentified with FATHER.

Subject fuses his conscious and preconscious images of —.

Subject diffuses his conscious and preconscious images of —.

Subject displaces his preconscious image of — onto his conscious perception of —.

Clinical Notes

FIGURE 61 (*concluded*)

His own view of self is far removed from his ego ideal. He is, therefore, dissatisfied with himself and desires to be a stronger and more executive person.

His "preconscious" scores fall close to his perceptions of mother and wife. This means that there is a "preconscious" identification with the idealized female figures. Consciously he is, of course, more identified with the weaker father and disidentified with mother and wife.

It will be noted that all seven interpersonal scores fall on the right (conventional) side of the diagnostic circle and none on the left (rebellious) side. The conflict axis lies between power and docility. This indicates that any "movement" or change in therapy will take place vertically on the right side of the diagnostic circle.

Clinical Implications

1. Motivation. The patient is initially well motivated for psychotherapy. He is pushed by symptoms of anxiety and depression. He is consciously dissatisfied with himself. His overt security operations are dependent, which makes it easy and natural for him to play the part of a patient.

2. Preconscious Conflicts and Defense Mechanisms. A conflict exists between overt docility-masochism and "preconscious" power. To be strong is to be feminine—i.e., like mother and wife. To be masculine (like father) means to be passive. Figure 61 includes the variability indices of interlevel conflict [1] and verbal summaries of these indices.

It will be seen that this patient represses power and nurturance, that he is consciously identified with his father and disidentified with his mother and his wife, and that he is "preconsciously" identified with these female relatives.

[1] The variability index figures cited in Figure 61 are based on the methodology described in Chapter 13. The indices of discrepancy on Dominance and Love are calculated separately and indicate what is repressed or misperceived. These two orthogonal linear indices (vertical and horizontal) are the sides of a right triangle the hypotenuse of which is the linear discrepancy distance. The hypotenuse of this triangle is the variability index (d); the two sides of the triangle indicate whether dominance (+) or passivity (−) and love (+) or hostility (−) are involved in the discrepancy. The weighted scores are based on mathematical procedures outlined in Chapter 13. In Appendix 5 will be found a complete listing of the weighted scores for every possible combination of scores (i.e., interlevel discrepancies or changes in the same level over time).

Figure 61 contains a column for entering the standard scores for discrepancies. At the present time the normative studies have not been completed and tables of standard scores are not available. For this reason this column is left blank. The plotting of variability indices on the diagram is based on an arbitrary (and tentative) scaling and included for illustrative purposes.

3. Predicted Interpersonal Reactions to Psychotherapy. This patient will present himself as docile and helpless. He will exert tremendous dependent pressure on the therapist, attempting to provoke reassurance, sympathy, and approval.

The underlying feelings of power will, however, lead the patient to private reservations and covert feelings of stubborn superiority. The patient pulls for sympathy but privately does not want to be seen as passive. A power struggle could develop unless the therapist avoids these powerful reflexes.

The underlying power motivation suggests that the patient will not remain passive and will try to end therapy through becoming normal and responsible.

The sequence to be expected is therefore: docility followed by dominance.

He will initially attempt to provoke maternal strength from the therapist. He will then tend (if the therapist is a male) to assume power and to derogate and master the therapist.

4. Prognosis. The prognosis for psychotherapy is in general positive. There are no indications of psychotic processes. The underlying feelings of responsibility forecast a healthy resolution of the symptomatic pressures. He is considered a good candidate for brief symptom-oriented psychotherapy.

The tangled nature of the sexual identification suggests that basic changes in the personality would not be expected short of psychoanalysis. He is therefore considered a good bet only for brief counseling. He will probably repress out of therapy and move towards a closer identification with his family members.

He cannot be expected to move towards masculine independence or rebellion from the close family ties.

Case History

The clinician who handled this case provided a case history which was written without knowledge of the test results.

Clinical Summary. A 40-year-old auto mechanic, self-referred with complaints of insomnia, hypertension, dizzy spells, blurry vision, prostate trouble, etc. These symptoms had begun six months ago, when a friend of the patient's who had many similar symptoms died of a heart attack following a prostate operation. The patient's physical condition was aggravated by business developments he did not feel competent to handle. The patient's home situation was apparently satisfactory ("wife and I get along nicely"), though in the last year or so he hadn't been quite the man he used to be; he had less sexual

desire than he used to have. He came from a Jewish family who lived in a Catholic, anti-Semitic neighborhood; the parents fought constantly. Patient was the second of six children. He had worked at various jobs, suffered much in the depression, finally took up auto mechanics which had been his hobby.

Impression: very nice guy—long history of hypochondriasis—feelings of inadequacy which he is very aware of. Passivity problems.

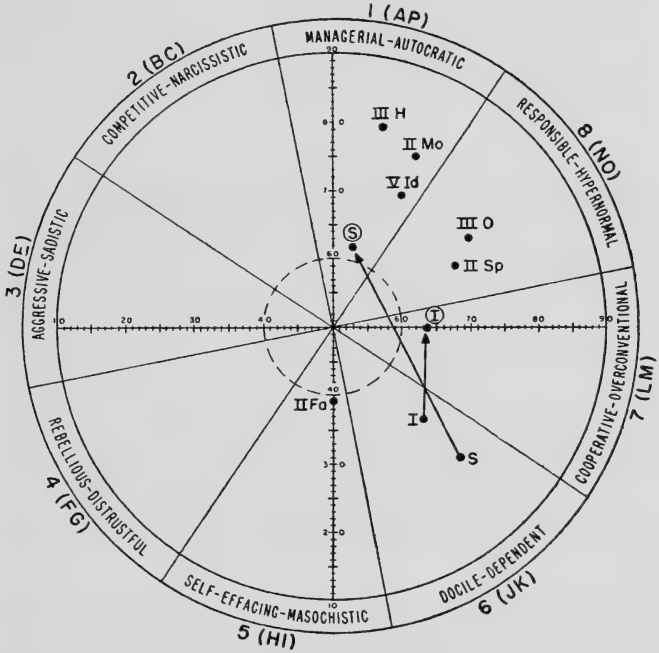


FIGURE 62. Multilevel Profile of Illustrative Patient Before Psychotherapy and Level I-M and II-C Scores After Psychotherapy.

Key: Before therapy: 6618–158–1
After Therapy: 71

I = Level I-M before therapy
S = Conscious view of self
H = Level III-T Hero
O = Level III-T Other
M = Conscious view of mother
F = Conscious view of father
Sp = Conscious view of spouse
Id = Level V–Ego Ideal
Ⓘ = Level I-M after therapy
Ⓢ = Level II-C–Conscious view of self after therapy

Prior to the second interview the patient called to say his private M.D. had kicked him out since he was getting psychiatric care, he had no more sleeping pills, and what to do. It was suggested he go to the medical clinic for a work up, which he did. He was looking and feeling much better at the second interview after having stopped medication even though he still couldn't sleep. Therapy was discussed and the patient showed some resistance as to cost and daytime hours but accepted it as inevitable. He was seen in individual therapy fifteen times. Close-out report states "patient is a severe phobic . . . ; motivation was always a problem—he wanted answers. We both agree that his symptoms are the price he pays for his satisfactory (to him) way of life." There was some symptomatic improvement.

Closing Diagnosis. Obsessive neurosis with phobic features.

Posttherapy Test Profile. This patient was administered the Interpersonal Check List and the MMPI after fifteen sessions of individual psychotherapy. The pre- and posttherapy scores are presented in Figure 62. A dramatic symptomatic improvement was recorded. His Level I-M index ① moves in the direction of increased power and decreased passivity. He ends up (at Level I) with the diagnosis of overconventional (hysteric) personality. He no longer admits to fears, worries, and depression but claims conventional adjustment.

In his self-description the same direction of change occurs. He sees himself after therapy as a confident, executive person. This revision, it will be noted, brings him into a much closer identification with his female relatives. He is utilizing (at this level) the security operations that characterize his mother and wife. The permanence or basic efficiency of this adjustment may be questioned but it is clear that considerable symptomatic relief has occurred through this repressive process and that the patient is currently happy with this resolution.

Reference

1. Gill, M., R. Newman, and F. Redlich. *The initial interview in psychiatric practice.* New York: International Universities Press, 1954.

5

Norms, Conversion Tables, and Weighted Scores Used in Interpersonal Diagnosis

In the interpersonal system the diagnosis at each level is assigned automatically and objectively by locating the intersection of the vertical (Dominance-Submission) and horizontal (Love-Hostility) indices on the diagnostic grid. This procedure is described in Chapter 12. The center of the diagnostic grid is determined by the intersection of the means of the horizontal and vertical distribution of a normative psychiatric clinic admission sample. In order to arrive at the interpersonal diagnosis, it is necessary to convert the raw scores (Dominance and Love) to standard scores at each level.

Table 54 presents the norms used for converting raw scores at Level I-M to standard scores.[1] Table 55 lists the norms for Level II-C. Tables 56 and 57 present the norms for Level III TAT (Hero) and (Other) respectively.

The system for measuring discrepancies between levels or between two tests at the same level administered at different times is presented in Chapter 13. Three indices of variability are derived from each pair of diagnostic codes to be compared. The Dom index indicates the amount of discrepancy between the two levels on the dominance-submission axis. The Lov index indicates the amount of discrepancy on the love-hostility axis. The Dom and the Lov indices thus define the *kind* of discrepancy. The amount of discrepancy is indicated by the "d" value.

The weighted scores assigned to the discrepancy between each pair of interlevel scores (or between scores at the same level obtained at different times) are presented in Table 58. It will be noted that

[1] Templates and diagnostic grids used for interpersonal diagnosis have been published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California.

TABLE 54

NORMS FOR CONVERTING RAW SCORES (DOM AND LOV) TO STANDARD SCORES AT LEVEL I-M (STANDARDIZED ON KAISER FOUNDATION PSYCHOLOGY RESEARCH SAMPLES B, Cl-1, Cl-2)

Dom	Standard Score	Lov	Dom	Standard Score	Lov
+47, 48, 49	80	+74, 75, 76			
+45, 46	79	+72, 73	-26, 27	49	- 8, 9, 10
+42, 43, 44	78	+69, 70, 71	-28, 29, 30	48	-11, 12
+40, 41	77	+66, 67, 68	-31, 32	47	-13, 14, 15
+38, 39	76	+64, 65	-33, 34, 35	46	-16, 17, 18
+35, 36, 37	75	+61, 62, 63	-36, 37	45	-19, 20, 21
+33, 34	74	+58, 59, 60	-38, 39, 40	44	-22, 23
+30, 31, 32	73	+55, 56, 57	-41, 42	43	-24, 25, 26
+28, 29	72	+53, 54	-43, 44	42	-27, 28, 29
+25, 26, 27	71	+50, 51, 52	-45, 46, 47	41	-30, 31
+23, 24	70	+47, 48, 49	-48, 49	40	-32, 33, 34
+21, 22	69	+45, 46	-50, 51, 52	39	-35, 36
+18, 19, 20	68	+42, 43, 44	-53, 54	38	-37, 38, 39
+16, 17	67	+39, 40, 41	-55, 56	37	-40, 41, 42
+13, 14, 15	66	+37, 38	-57, 58, 59	36	-43, 44, 45
+11, 12	65	+34, 35, 36	-60, 61	35	-46, 47, 48
+ 9, 10	64	+31, 32, 33	-62, 63, 64	34	-49, 50
+ 6, 7, 8	63	+28, 29, 30	-65, 66	33	-51, 52, 53
+ 4, 5	62	+26, 27	-67, 68	32	-54, 55, 56
+ 1, 2, 3	61	+23, 24, 25	-69, 70, 71	31	-57, 58
- 1, 0	60	+20, 21, 22	-72, 73	30	-59, 60, 61
- 2, 3	59	+17, 18, 19	-74, 75, 76	29	-62, 63, 64
- 4, 5, 6	58	+15, 16	-77, 78	28	-65, 66, 67
- 7, 8	57	+12, 13, 14	-79, 80, 81	27	-68, 69
- 9, 10, 11	56	+ 9, 10, 11	-82, 83	26	-70, 71, 72
-12, 13	55	+ 7, 8	-84, 85	25	-73, 74, 75
-14, 15	54	+ 4, 5, 6	-86, 87, 88	24	-76, 77
-16, 17, 18	53	+ 1, 2, 3	-89, 90	23	-78, 79, 80
-19, 20	52	0, -1, 2	-91, 92, 93	22	-81, 82, 83
-21, 22, 23	51	- 3, 4	-94, 95	21	-84, 85, 86
-24, 25	50	- 5, 6, 7	-96, 97, 98	20	-87, 88

TABLE 55

NORMS FOR CONVERTING RAW SCORES (DOM AND LOV) TO STANDARD SCORES AT LEVEL II-C (FOR USE WITH INTERPERSONAL CHECK LIST, FORM 4) (STANDARDIZED ON KAISER FOUNDATION RESEARCH SAMPLE G)

Dom		Std. Score	Lov		Std. Score	Dom		Std. Score	Lov		Std. Score
+37.8	+38.4	102									
+37.0	+37.7	101									
+36.2	+36.9	100				- 2.5	- 3.2	50	+ 1.2	+ 2.0	50
+35.4	+36.1	99				- 3.3	- 4.0	49	+ 0.3	+ 1.1	49
+34.6	+35.3	98				- 4.1	- 4.8	48	+ 0.2	- 0.6	48
+33.8	+34.5	97				- 4.9	- 5.6	47	- 0.7	- 1.4	47
+33.0	+33.7	96				- 5.7	- 6.4	46	- 1.5	- 2.3	46
+32.2	+32.9	95				- 6.5	- 7.2	45	- 2.4	- 3.2	45
+31.5	+32.1	94				- 7.3	- 8.0	44	- 3.3	- 4.1	44
+30.7	+31.4	93				- 8.1	- 8.7	43	- 4.2	- 5.0	43
+29.9	+30.6	92				- 8.8	- 9.5	42	- 5.1	- 5.9	42
+29.1	+29.8	91	+37.6	+38.4	91	- 9.6	-10.3	41	- 6.0	- 6.8	41
+28.3	+29.0	90	+36.7	+37.5	90	-10.4	-11.1	40	- 6.9	- 7.7	40
+27.5	+28.2	89	+35.9	+36.6	89	-11.2	-11.9	39	- 7.8	- 8.5	39
+26.7	+27.4	88	+35.0	+35.8	88	-12.0	-12.7	38	- 8.6	- 9.4	38
+25.9	+26.6	87	+34.1	+34.9	87	-12.8	-13.5	37	- 9.5	-10.3	37
+25.2	+25.8	86	+33.2	+34.0	86	-13.6	-14.3	36	-10.4	-11.2	36
+24.4	+25.1	85	+32.3	+33.1	85	-14.4	-15.0	35	-11.3	-12.1	35
+23.6	+24.3	84	+31.4	+32.2	84	-15.1	-15.8	34	-12.2	-13.0	34
+22.8	+23.5	83	+30.5	+31.3	83	-15.9	-16.6	33	-13.1	-13.9	33
+22.0	+22.7	82	+29.6	+30.4	82	-16.7	-17.4	32	-14.0	-14.8	32
+21.2	+21.9	81	+28.8	+29.5	81	-17.5	-18.2	31	-14.9	-15.6	31
+20.4	+21.1	80	+27.9	+28.7	80	-18.3	-19.0	30	-15.7	-16.5	30
+19.6	+20.3	79	+27.0	+27.8	79	-19.1	-19.8	29	-16.6	-17.4	29
+18.9	+19 5	78	+26.1	+26.9	78	-19.9	-20.6	28	-17.5	-18.3	28
+18.1	+18 8	77	+25.2	+26.0	77	-20.7	-21.3	27	-18.4	-19.2	27
+17.3	+18.0	76	+24.3	+25.1	76	-21.4	-22.1	26	-19.3	-20.1	26
+16.5	+17.2	75	+23.4	+24.2	75	-22.2	-22.9	25	-20.2	-21.0	25
+15.7	+16.4	74	+22.5	+23.3	74	-23.0	-23.7	24	-21.1	-21.9	24
+14.9	+15.6	73	+21.7	+22.4	73	-23.8	-24.5	23	-22.0	-22.8	23
+14.1	+14.8	72	+20.8	+21.6	72	-24.6	-25.3	22	-22.9	-23.6	22
+13.3	+14.0	71	+19.9	+20.7	71	-25.4	-26.1	21	-23.7	-24.5	21
+12.5	+13.2	70	+19.0	+19.8	70	-26.2	-26.9	20	-24.6	-25.4	20
+11.7	+12.4	69	+18.1	+18.9	69	-27.0	-27.6	19	-25.5	-26.3	19
+11.0	+11.6	68	+17.2	+18.0	68	-27.7	-28.4	18	-26.4	-27.2	18
+10.2	+10.9	67	+16.3	+17.1	67	-28.5	-29.2	17	-27.3	-28.1	17
+ 9.4	+10.1	66	+15.4	+16.2	66	-29.3	-30.0	16	-28.2	-29.0	16
+ 8.6	+ 9.3	65	+14.5	+15.3	65	-30.1	-30.8	15	-29.1	-29.9	15
+ 7.8	+ 8.5	64	+13.7	+14.4	64	-30.9	-31.6	14	-30.0	-30 7	14
+ 7.0	+ 7.7	63	+12.8	+13.6	63	-31.7	-32.4	13	-30.8	-31.6	13
+ 6.2	+ 6.9	62	+11.9	+12.7	62	-32.5	-33.2	12	-31.7	-32.5	12
+ 5.4	+ 6.1	61	+11.0	+11.8	61	-33.3	-33.9	11	-32.6	-33 4	11
+ 4.7	+ 5.3	60	+10.1	+10.9	60	-34.0	-34.7	10	-33.5	-34.3	10
+ 3.9	+ 4.6	59	+ 9.2	+10.0	59	-34.8	-35.5	9	-34.4	-35.2	9
+ 3.1	+ 3.8	58	+ 8.3	+ 9.1	58	-35.6	-36.3	8	-35.3	-36.1	8
+ 2.3	+ 3.0	57	+ 7.4	+ 8.2	57	-36.4	-37.1	7	-36.2	-37.0	7
+ 1.5	+ 2.2	56	+ 6.6	+ 7.3	56	-37.2	-37.9	6	-37.1	-37.9	6
+ 0.7	+ 1.4	55	+ 5.7	+ 6.5	55	-38.0	-38.4	5	-38.0	-38.4	5
- 0.1	+ 0.6	54	+ 4.8	+ 5.6	54						
- 0.2	- 0.9	53	+ 3.9	+ 4.7	53						
- 1.0	- 1.6	52	+ 3.0	+ 3.8	52						
- 1.7	- 2.4	51	+ 2.1	+ 2.9	51						

TABLE 56

NORMS FOR CONVERTING RAW SCORES (DOM AND LOV) TO STANDARD SCORES AT LEVEL III-TAT (HERO) (STANDARDIZED ON KAISER FOUNDATION PSYCHOLOGY RESEARCH SAMPLE 100)

Dom		Std. Score	Lov		Std. Score	Dom		Std. Score	Lov		Std. Score
+7.7	+7.9	90	+11.9	+12.1	90						
+7.4	+7.6	89	+11.6	+11.8	89	- 5.9	- 6.1	49	- 0.1	- 0.3	49
+7.0	+7.3	88	+11.3	+11.5	88	- 6.2	- 6.5	48	- 0.4	- 0.6	48
+6 7	+6.9	87	+11.0	+11.2	87	- 6.6	- 6 8	47	- 0.7	- 0.9	47
+6 3	+6.6	86	+10.7	+10.9	86	- 6.9	- 7.1	46	- 1.0	- 1.2	46
+6.0	+6.2	85	+10.4	+10.6	85	- 7.2	- 7.5	45	- 1.3	- 1.5	45
+5.7	+5.9	84	+10.1	+10.3	84	- 7.6	- 7.8	44	- 1.6	- 1.8	44
+5.3	+5.6	83	+ 9 8	+10.0	83	- 7.9	- 8.1	43	- 1.9	- 2.1	43
+5.0	+5.2	82	+ 9.5	+ 9.7	82	- 8.2	- 8.5	42	- 2.2	- 2.4	42
+4.7	+4.9	81	+ 9.2	+ 9.4	81	- 8.6	- 8 8	41	- 2.5	- 2.7	41
+4.3	+4.6	80	+ 8.9	+ 9.1	80	- 8.9	- 9.2	40	- 2.8	- 3.0	40
+4.0	+4.2	79	+ 8.6	+ 8.8	79	- 9.3	- 9.5	39	- 3.1	- 3.3	39
+3.6	+3.9	78	+ 8.3	+ 8.5	78	- 9.6	- 9.8	38	- 3.4	- 3.6	38
+3.3	+3.5	77	+ 8.0	+ 8.2	77	- 9.9	-10.2	37	- 3.7	- 3.9	37
+3.0	+3.2	76	+ 7.7	+ 7.9	76	-10.3	-10.5	36	- 4.0	- 4.2	36
+2.6	+2.9	75	+ 7.4	+ 7.6	75	-10.6	-10.8	35	- 4.3	- 4.5	35
+2.3	+2.5	74	+ 7.1	+ 7.3	74	-10.9	-11.2	34	- 4.6	- 4.8	34
+2.0	+2.2	73	+ 6.8	+ 7.0	73	-11.3	-11.5	33	- 4.9	- 5.1	33
+1.6	+1.9	72	+ 6.5	+ 6.7	72	-11.6	-11.9	32	- 5.2	- 5.4	32
+1.3	+1.5	71	+ 6.2	+ 6.4	71	-12.0	-12.2	31	- 5.5	- 5.7	31
+1.0	+1.2	70	+ 6.0	+ 6.1	70	-12.3	-12.5	30	- 5.8	- 6.0	30
+0.6	+0.9	69	+ 5.7	+ 5.9	69	-12.6	-12.9	29	- 6.1	- 6.3	29
+0.3	+0.5	68	+ 5.4	+ 5.6	68	-13.0	-13.2	28	- 6.4	- 6.6	28
-0.1	+0.2	67	+ 5.1	+ 5.3	67	-13.3	-13.5	27	- 6.7	- 6.9	27
-0.2	-0.4	66	+ 4.8	+ 5.0	66	-13.6	-13.9	26	- 7.0	- 7.2	26
-0.5	-0.7	65	+ 4.5	+ 4.7	65	-14.0	-14.2	25	- 7.3	- 7.5	25
-0.8	-1.1	64	+ 4.2	+ 4.4	64	-14.3	-14.6	24	- 7.6	- 7.8	24
-1.2	-1.4	63	+ 3.9	+ 4.1	63	-14.7	-14.9	23	- 7.9	- 8.1	23
-1.5	-1.7	62	+ 3.6	+ 3.8	62	-15.0	-15.2	22	- 8.2	- 8.4	22
-1.8	-2.1	61	+ 3.3	+ 3.5	61	-15.3	-15.6	21	- 8.5	- 8.7	21
-2.2	-2.4	60	+ 3.0	+ 3.2	60	-15.7	-15.9	20	- 8.8	- 8.9	20
-2.5	-2.8	59	+ 2.7	+ 2.9	59	-16.0	-16.2	19	- 9.0	- 9.2	19
-2.9	-3.1	58	+ 2.4	+ 2.6	58	-16.3	-16.6	18	- 9.3	- 9.5	18
-3.2	-3.4	57	+ 2.1	+ 2.3	57	-16.7	-16.9	17	- 9.6	- 9.8	17
-3.5	-3.8	56	+ 1.8	+ 2.0	56	-17.0	-17.2	16	- 9.9	-10.1	16
-3.9	-4.1	55	+ 1.5	+ 1.7	55	-17.3	-17.6	15	-10.2	-10 4	15
-4.2	-4.4	54	+ 1.2	+ 1.4	54	-17.7	-17.9	14	-10.5	-10.7	14
-4.5	-4.8	53	+ 0.9	+ 1.1	53	-18.0	-18.3	13	-10 8	-11.0	13
-4.9	-5.1	52	+ 0.6	+ 0.8	52	-18.4	-18.6	12	-11.1	-11 3	12
-5.2	-5.5	51	+ 0.3	+ 0.5	51	-18.5	-18.9	11	-11.4	-11.6	11
-5.6	-5 8	50	0.0	+ 0.2	50	-19 0	-19.3	10	-11.7	-11 9	10

TABLE 57

NORMS FOR CONVERTING RAW SCORES (DOM AND LOV) TO STANDARD SCORES AT LEVEL III-TAT (OTHER) (STANDARDIZED ON KAISER FOUNDATION PSYCHOLOGY RESEARCH SAMPLE 100)

Dom		Std. Score	Lov		Std. Score	Dom		Std. Score	Lov		Std. Score
+9.5	+9.7	90	+10.0	+10.2	90						
+9.3	+9.4	89	+ 9.8	+ 9.9	89	−0.5	−0.4	49	− 0.4	− 0.6	49
+9.0	+9.2	88	+ 9.5	+ 9.7	88	−0.5	−0.6	48	− 0.7	− 0.9	48
+8.8	+8.9	87	+ 9.2	+ 9.4	87	−0.7	−0.8	47	− 0.1	− 1.1	47
+8.6	+8.7	86	+ 9.0	+ 9.1	86	−0.9	−1.1	46	− 1.2	− 1.4	46
+8.3	+8.5	85	+ 8.7	+ 8.9	85	−1.2	−1.3	45	− 1.5	− 1.6	45
+8.1	+8.2	84	+ 8.5	+ 8.6	84	−1.4	−1.6	44	− 1.7	− 1.9	44
+7.8	+8.0	83	+ 8.2	+ 8.4	83	−1.7	−1.8	43	− 2.0	− 2.2	43
+7.6	+7.7	82	+ 7.9	+ 8.1	82	−1.9	−2.0	42	− 2.3	− 2.4	42
+7.4	+7.5	81	+ 7.7	+ 7.8	81	−2.1	−2.3	41	− 2.5	− 2.7	41
+7.1	+7.3	80	+ 7.4	+ 7.6	80	−2.4	−2.5	40	− 2.8	− 2.9	40
+6.9	+7.0	79	+ 7.2	+ 7.3	79	−2.6	−2.8	39	− 3.0	− 3.2	39
+6.6	+6.8	78	+ 6.9	+ 7.1	78	−2.9	−3.0	38	− 3.3	− 3.4	38
+6.4	+6.5	77	+ 6.7	+ 6.8	77	−3.1	−3.2	37	− 3.5	− 3.7	37
+6.2	+6.3	76	+ 6.4	+ 6.6	76	−3.3	−3.5	36	− 3.8	− 4.0	36
+5.9	+6.1	75	+ 6.1	+ 6.3	75	−3.6	−3.7	35	− 4.1	− 4.2	35
+5.7	+5.8	74	+ 5.9	+ 6.0	74	−3.8	−4.0	34	− 4.3	− 4.5	34
+5.4	+5.6	73	+ 5.6	+ 5.8	73	−4.1	−4.2	33	− 4.6	− 4.7	33
+5.2	+5.3	72	+ 5.4	+ 5.5	72	−4.3	−4.4	32	− 4.8	− 5.0	32
+5.0	+5.1	71	+ 5.1	+ 5.3	71	−4.5	−4.7	31	− 5 1	− 5.3	31
+4.7	+4.9	70	+ 4.8	+ 5.0	70	−4.8	−4.9	30	− 5.4	− 5.5	30
+4.5	+4.6	69	+ 4.6	+ 4.7	69	−5.0	−5.2	29	− 5.6	− 5.8	29
+4.2	+4.4	68	+ 4.3	+ 4.5	68	−5.3	−5.4	28	− 5.9	− 6.0	28
+4.0	+4.1	67	+ 4.1	+ 4.2	67	−5.5	−5.7	27	− 6.1	− 6.3	27
+3.7	+3.9	66	+ 3.8	+ 4.0	66	−5.8	−5.9	26	− 6.4	− 6.6	26
+3.5	+3.6	65	+ 3.5	+ 3.7	65	−6.0	−6.1	25	− 6.7	− 6.8	25
+3.3	+3.4	64	+ 3.3	+ 3.4	64	−6.2	−6.4	24	− 6.9	− 7.1	24
+3.0	+3.2	63	+ 3.0	+ 3.2	63	−6.5	−6.6	23	− 7.2	− 7.3	23
+2.8	+2.9	62	+ 2.8	+ 2.9	62	−6.7	−6.9	22	− 7.4	− 7.6	22
+2.5	+2.7	61	+ 2.5	+ 2.7	61	−7.0	−7.1	21	− 7.7	− 7.9	21
+2.3	+2.4	60	+ 2.3	+ 2.4	60	−7.2	−7.3	20	− 8.0	− 8.1	20
+2.1	+2.2	59	+ 2.0	+ 2.2	59	−7.4	−7.6	19	− 8.2	− 8.4	19
+1.8	+2.0	58	+ 1.7	+ 1.9	58	−7.7	−7.8	18	− 8.5	− 8.6	18
+1.6	+1.7	57	+ 1.5	+ 1.6	57	−7.9	−8.1	17	− 8.7	− 8.9	17
+1.3	+1.5	56	+ 1.2	+ 1.4	56	−8.2	−8.3	16	− 9.0	− 9.1	16
+1.1	+1 2	55	+ 1.0	+ 1.1	55	−8.4	−8.5	15	− 9.2	− 9.4	15
+0.9	+1.0	54	+ 0.7	+ 0.9	54	−8.6	−8.8	14	− 9.5	− 9.7	14
+0.6	+0.8	53	+ 0.4	+ 0.6	53	−8.9	−9.0	13	− 9.8	− 9.9	13
+0.4	+0 5	52	+ 0.2	+ 0.3	52	−9.1	−9.3	12	−10.0	−10.2	12
+0.1	+0.3	51	− 0.1	+ 0.1	51	−9.4	−9.5	11	−10.3	−10.4	11
−0 1	0 0	50	− 0.2	− 0.3	50	−9 6	−9.8	10	−10.5	−10.7	10

TABLE 58

WEIGHTED SCORES FOR MEASURING DISCREPANCY BETWEEN TWO DIAGNOSTIC CODES INDICATING KIND AND AMOUNT OF DIFFERENCE BETWEEN LEVELS OR TESTS

Weighted Scores Used to Compare Diagnostic Codes of Extreme Intensity (Both Roman Codes)

Weighted Scores Used to Compare Diagnostic Codes of Moderate Intensity (Both Italic Codes)

Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d
11	00	00	00	21	+ 9	+ 43	44	*11*	00	00	00	*21*	+ 5	+25	26
12	- 9	- 43	44	22	00	00	00	*12*	- 5	-25	26	*22*	00	00	00
13	- 45	- 67	81	23	- 36	- 24	44	*13*	-27	-39	48	*23*	-22	-14	26
14	- 88	- 58	105	24	- 79	- 15	81	*14*	-52	-34	62	*24*	-47	- 9	48
15	-112	- 22	114	25	-103	+ 21	105	*15*	-66	-12	68	*25*	-61	+13	62
16	-103	+ 21	105	26	- 94	+ 64	114	*16*	-61	+13	62	*26*	-56	+38	68
17	- 67	+ 45	81	27	- 58	+ 88	105	*17*	-39	+27	48	*27*	-34	+52	62
18	- 24	+ 36	44	28	- 15	+ 79	81	*18*	-14	+22	26	*28*	- 9	+47	48
31	+ 45	+ 67	81	41	+ 88	+ 58	105	*31*	+27	+39	48	*41*	+52	+34	62
32	+ 36	+ 24	44	42	+ 79	+ 15	81	*32*	+22	+14	26	*42*	+47	+ 9	48
33	00	00	00	43	+ 43	- 9	44	*33*	00	00	00	*43*	+25	- 5	26
34	- 43	+ 9	44	44	00	00	00	*34*	-25	+ 5	26	*44*	00	00	00
35	- 67	+ 45	81	45	- 24	+ 36	44	*35*	-39	+27	48	*45*	-14	+22	26
36	- 58	+ 88	105	46	- 15	+ 79	81	*36*	-34	+52	62	*46*	- 9	+47	48
37	- 22	+112	114	47	+ 21	+103	105	*37*	-12	+66	68	*47*	+13	+61	62
38	+ 21	+103	105	48	+ 64	+ 94	114	*38*	+13	+61	62	*48*	+38	+56	68
51	+112	+ 22	114	61	+103	- 21	105	*51*	+66	+12	68	*61*	+61	-13	62
52	+103	- 21	105	62	+ 94	- 64	114	*52*	+61	-13	62	*62*	+56	-38	68
53	+ 67	- 45	81	63	+ 58	- 88	105	*53*	+39	-27	48	*63*	+34	-52	62
54	+ 24	- 36	44	64	+ 15	- 79	81	*54*	+14	-22	26	*64*	+ 9	-47	48
55	00	00	00	65	- 9	- 43	44	*55*	00	00	00	*65*	- 5	-25	26
56	+ 9	+ 43	44	66	00	00	00	*56*	+ 5	+25	26	*66*	00	00	00
57	+ 45	+ 67	81	67	+ 36	+ 24	44	*57*	+27	+39	48	*67*	+22	+14	26
58	+ 88	+ 58	105	68	+ 79	+ 15	81	*58*	+52	+34	62	*68*	+47	+ 9	48
71	+ 67	- 45	81	81	+ 24	- 36	44	*71*	+39	-27	48	*81*	+14	-22	26
72	+ 58	- 88	105	82	+ 15	- 79	81	*72*	+34	-52	62	*82*	+ 9	-47	48
73	+ 22	-112	114	83	- 21	-103	105	*73*	+12	-66	68	*83*	-13	-61	62
74	- 21	-103	105	84	- 64	- 94	114	*74*	-13	-61	62	*84*	-38	-56	68
75	- 45	- 67	81	85	- 88	- 58	105	*75*	-27	-39	48	*85*	-52	-34	62
76	- 36	- 24	44	86	- 79	- 15	81	*76*	-22	-14	26	*86*	-47	- 9	48
77	00	00	00	87	- 43	+ 9	44	*77*	00	00	00	*87*	-25	+ 5	26
78	+ 43	- 9	44	88	00	00	00	*78*	+25	- 5	26	*88*	00	00	00

TABLE 58 (*Continued*)

Weighted Scores Used To Compare Diagnostic Codes Where One Diagnostic Code Is of Extreme and the Other Is of Moderate Intensity

Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d
11	−23	− 5	23	21	−14	+38	41	11	+23	+ 5	23	21	+28	+30	41
12	−28	−30	41	22	−19	+13	23	12	+14	−38	41	22	+19	−13	23
13	−50	−44	66	23	−41	− 1	41	13	−22	−62	66	23	−17	−37	41
14	−75	−39	84	24	−66	+ 4	66	14	−65	−53	84	24	−60	−28	66
15	−89	−17	91	25	−80	+26	84	15	−89	−17	91	25	−84	+ 8	84
16	−84	+ 8	84	26	−75	+51	91	16	−80	+26	84	26	−75	+51	91
17	−62	+22	66	27	−53	+65	84	17	−44	+50	66	27	−39	+75	84
18	−37	+17	41	28	−28	+60	66	18	− 1	+41	41	28	+ 4	+66	66
31	+22	+62	66	41	+65	+53	84	31	+50	+44	66	41	+75	+39	84
32	+17	+37	41	42	+60	+28	66	32	+41	+ 1	41	42	+66	− 4	66
33	− 5	+23	23	43	+38	+14	41	33	+ 5	−23	23	43	+30	−28	41
34	−30	+28	41	44	+13	+19	23	34	−38	−14	41	44	−13	−19	23
35	−44	+50	66	45	− 1	+41	41	35	−62	+22	66	45	−37	+17	41
36	−39	+75	84	46	+ 4	+66	66	36	−53	+65	84	46	−28	+60	66
37	−17	+89	91	47	+26	+80	84	37	−17	+89	91	47	+ 8	+84	84
38	+ 8	+84	84	48	+51	+75	91	38	+26	+80	84	48	+51	+75	91
51	+89	+17	91	61	+80	−26	84	51	+89	+17	91	61	+84	− 8	84
52	+84	− 8	84	62	+75	−51	91	52	+80	−26	84	62	+75	−51	91
53	+62	−22	66	63	+53	−65	84	53	+44	−50	66	63	+39	−75	84
54	+37	−17	41	64	+28	−60	66	54	+ 1	−41	41	64	− 4	−66	66
55	+23	+ 5	23	65	+14	−38	41	55	−23	− 5	23	65	−28	−30	41
56	+28	+30	41	66	+19	−13	23	56	−14	+38	41	66	−19	+13	23
57	+50	+44	66	67	+41	+ 1	41	57	+22	+62	66	67	+17	+37	41
58	+75	+39	84	68	+66	− 4	66	58	+65	+53	84	68	+60	+28	66
71	+44	−50	66	81	+ 1	−41	41	71	+62	−22	66	81	+37	−17	41
72	+39	−75	84	82	− 4	−66	66	72	+53	−65	84	82	+28	−60	66
73	+17	−89	91	83	−26	−80	84	73	+17	−89	91	83	− 8	−84	84
74	− 8	−84	84	84	−51	−75	91	74	−26	−80	84	84	−51	−75	91
75	−22	−62	66	85	−65	−53	84	75	−50	−44	66	85	−75	−39	84
76	−17	−37	41	86	−60	−28	66	76	−41	− 1	41	86	−66	+ 4	66
77	+ 5	−23	23	87	−38	−14	41	77	− 5	+23	23	87	−30	+28	41
78	+30	−28	41	88	−13	−19	23	78	+38	+14	41	88	+13	+19	23

Table 58 is divided into two sections. The first part lists the weighted scores used to compare diagnostic codes of the same intensity—i.e., both extreme (indicated by arabic numerals) or both moderate (indicated by italicized numerals). If the diagnosis at one level is intense and the diagnosis at the other level moderate (or vice versa) the second section of Table 58 is used.

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In the decade before he became the highly controversial director of psychedelic drug research at Harvard, Timothy Leary was one of the leading clinical psychologists practicing in the U.S., heading the prestigious Kaiser Foundation Psychological Research Center in Oakland.

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